AIR FORCE INSPECTION AGENCY

OFFICE OF THE INSPECTOR GENERAL

2005 TRIENNIAL INSPECTION REPORT

ARMED FORCES RETIREMENT HOME (AFRH)

1800 BEACH DR
GULFPORT MS 39507
18 – 22 July 2005

3700 NORTH CAPITOL ST NW
WASHINGTON DC 20011-8400
25 – 29 July 2005

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ACRONYMS:

AAFES: Army Air Force Exchange Service
ADA: Americans with Disabilities Act
AE: Architect and Engineering
AFGE: American Federation of Government Employees
AFIA: Air Force Inspection Agency
AFRH: Armed Forces Retirement Home
AFRH-G: Armed Forces Retirement Home-Gulfport
AFRH-W: Armed Forces Retirement Home-Washington
AI: Administrative Instruction
AL: Assisted Living
ANSI: American National Standards Institute
APC: Agency Program Coordinator
APIC: Association for Professionals in Infection Control and Epidemiology
ARC: Administrative Resource Center
ASHRAE: American Society of Heating, Refrigeration, Air Conditioning Engineers
BPD: Bureau of Public Debt
CC: Commander
CCTV: Closed Circuit Television
CEU: Continuing Education Unit
CFO: Chief Financial Officer
CFR: Code of Federal Regulations
CHCS: Composite Healthcare Computer System
CNA: Certified Nurse Assistant
CNP: Certified Nurse Practitioner
COO: Chief Operating Officer
COR: Contracting Officer Representative
COTR: Contracting Officer Technical Representative
CPR: Cardiac Pulmonary Resuscitation
CPS: Contractor Performance System
CV: Vice Commander
CY: Calendar Year
DAU: Defense Acquisition University
DOD: Department of Defense
DS3: Digital Signal level 3
DTAR: Department of Treasury Acquisition Regulation
EEO: Equal Employment Opportunity

EMC: Executive Management Committee
EPA: U.S. Environmental Protection Agency
FAR: Federal Acquisition Regulation
FASAB: Federal Accounting Standards Advisory Board
FISMA: Federal Information Systems Management Act
FOIA: Freedom of Information Act
FRES: Facility Readiness Evaluation System
FTE: Full-time Equivalent
FY: Fiscal Year
GAO: Government Accounting Office
GFM: Government Furnished Material
GFP: Government Furnished Property
GS: Governmental Services
HR: Human Resources
HRO: Human Resources Office
HVAC: Heating, Ventilation and Air Conditioning
IAW: In Accordance With
IBC: International Building Code
IDIQ: Indefinite Delivery Indefinite Quantity
IG: Inspector General
IL: Independent Living
ISP: Internet Service Provider
IT: Information Technology
JCAHO: Joint Commission on Accreditation of Healthcare Organizations
JFMIP: Joint Financial Management Improvement Program
KAFB: Keesler Air Force Base
KAFMC: Keesler Air Force Medical Center
LIUNA: Laborers International Union of North America
LPN: Licensed Practical Nurse
LTC: Long-Term Care
MAR: Medication Administration Records
MCD: Maintenance Control Director
MHS: Military Healthcare System
MOA: Memorandum of Agreement
MOU: Memorandum of Understanding
MPDC: Metropolitan Police Washington DC
MWR: Morale Welfare and Recreation
NA: Nursing Assistant

NAF: Non-appropriated Fund
NAFI: Non-appropriated Fund Instrumentality
NARA: National Archives Records Administration
NFPA: National Fire Protection Administration
NIOSH: National Institute for Occupational Safety and Health
NOK: Next of Kin
O&M: Operations and Maintenance
OMB: Office of Management and Budget
OPF: Official Personnel Folder
OPM: Office of Personnel Management
OPR: Office of Primary Responsibility
OSD: Office of Secretary of Defense
OSHA: Occupational Safety and Health Administration
OSHMP: Occupational Safety and Health Management Plan
PA: Privacy Act
PBSA: Performance Based Services Acquisition
PD: Position Description
PDUSD: Principal Deputy Under Secretary of Defense
PI: Performance Improvement
POV: Privately Owned Vehicle
PWS: Performance Work Statement
QA: Quality Assurance
QASP: Quality Assurance Surveillance Plan
RC: Record Custodian
RFP: Request for Proposal
RIF: Reduction in Force
RLW: Recreation, Leisure and Wellness
RM: Records Manager
RN: Registered Nurse
SAF: Secretary of the Air Force
SOP: Standard Operating Procedures
SOW: Statement of Work
STARS: Standing Time and Attendance Reporting System
T&M: Time and Materials
TMA: Tri-Service Medical Agency
TSP: Thrift Savings Plan
USA: United States Army
USN: United States Navy

VAMC: Veterans Administration Medical Center
WRAMC: Walter Reed Army Medical Center

SECTION I – EXECUTIVE SUMMARY

9 March 2006

MEMORANDUM FOR DEPUTY UNDER SECRETARY OF DEFENSE FOR MILITARY COMMUNITY AND FAMILY POLICY

FROM: HQ AFIA/FO
9700 G Avenue SE
Kirtland AFB NM 87117-5670

SUBJECT: Armed Forces Retirement Home 2005 Triennial Inspection Results

1. IAW Title 24 U.S.C. § 418(a-c) and ASD (FMP) memorandum, 11 February 1999, the Air Force Inspection Agency (AFIA) conducted an inspection of the Armed Forces Retirement Home (AFRH). On-site portions of the inspection were conducted at the Gulfport MS campus (AFRH-G), 18-22 July 2005 and at the Washington DC campus (AFRH-W), 25-29 July 2005. Additionally, Agency-level oversight, which included the Chief Operating Officer (COO) and his staff, was assessed during the AFRH-W visit. This report is forwarded for your distribution to the AFRH, Secretary of Defense and Congress.

2. The inspection team consisted of 20 people that included representatives from AFIA, Air Force Audit Agency, Air Force Civil Engineer Support Agency, Air Force Personnel Center, Air Force Safety Center and Department of Defense, Navy and Army Inspector General. The assembled team had specific expertise in contracting, safety, security, medical care, financial management/analysis, services, legal, mortuary affairs, information technology, human resources, civil engineering and records management. Team preparations included review of the 2002 Naval Inspector General Report and numerous discussions with Office of Secretary of Defense (OSD) and Department of Defense (DOD) personnel and AFRH leadership.

3. A synopsis of each primary area evaluated, along with a table of answerable findings, is provided in Tab A to the executive summary. The findings were assigned a cause code to assist AFRH leadership and OSD in determining the appropriate level of corrective action. Reply instructions are included in *Section III* of this report.

4. It should be noted that AFRH-G received extensive damage on 29 August 2005 from Hurricane Katrina. As a result, the majority of AFRH-G residents were relocated to AFRH-W. As of the date of this report, a decision has not been made on the status of AFRH-G. The inspection team identified 12 findings specific to AFRH-G operations. Of these 12 findings, four related directly to facilities and will not be answerable (J-01, J-03, J-04 and J-05). The other

eight findings related to program management and identified systemic deficiencies in the "one model" approach and should be answered by AFRH.

5. Overall, the inspection team found that AFRH provided quality care and a comfortable resident living environment. AFRH personnel managed the Home effectively and were committed to their core business--*running the premier retirement community for America's veterans*. Moreover, AFRH experienced a significant operations transformation in the services provided to the residents and in the working environment for the staff. The change was positive as AFRH evolved from inefficient management practices of the past to the "one model" approach of the future. Although necessary, the transformation was momentous as well as turbulent. Additionally, several significant deficiencies that impeded progress and required attention existed at the Agency level and at both campuses. The inspection team recommends that AFRH take a strategic pause to allow the residents and staff time to adjust to the transformation. Also, this would allow refinement to the "one model" approach.

//signed//
(b)(6) Colonel, USAF
Inspection Team Chief

Tab A
Executive Comments by Area Inspected

EXECUTIVE COMMENTS BY AREA INSPECTED

SENIOR MANAGEMENT

AFRH evolved significantly over the last three years and senior management made great strides to effect positive change across the Agency and campus structure. However, in the past year, progress was impeded due to either a transition in or lack of senior leadership at both campuses. The absence of an AFRH-W Director created a void in day-to-day leadership at that site.

Recently established partnerships with public and private agencies were force enablers for AFRH. AFRH benefited from economies that were not possible prior to the partnerships. However, senior leadership emphasis was required to continue establishing effective internal controls to ensure that AFRH received agreed upon services.

AFRH personnel provided quality services and support to the residents. At all levels, employees exhibited professional and caring attitudes. Residents and staff interacted in a positive manner. However, gaps in staff communications were noted. Often employees were not sure or aware of proper policy and procedures, forcing the inspection team to go to Agency-level personnel for clarification. At times, only the COO and/or Chief Financial Officer (CFO) could answer questions.

Contributing to the communications issues identified above was the current status of AFRH policy and guidance. As a whole, the Home's policy and guidance were out-of-date. In part, this was attributable to recent organizational changes; however, in several cases, policy and guidance were not updated in several years. This contributed to employees relying on draft written guidance and, in some cases, unwritten guidance or word of mouth.

The failure to use the Local Boards of Trustees as required by legislation was a significant management issue. Since the previous triennial inspection, the Local Boards met infrequently. According to AFRH COO and CFO, when the role of the Local Boards changed from a governing to an advisory body, the transition proved difficult.

HUMAN RESOURCES MANAGEMENT

During the past year, significant change occurred in the way human resources (HR) services were provided to appropriated fund employees within the Agency and at the Gulfport and Washington campuses. Starting October 2004, all HR services for both campuses, except employee benefits, were franchised to the Bureau of Public Debt (BPD), Parkersburg, WV. Three HR positions remained on the Agency staff to provide employee benefits services (i.e., retirements, health and life insurance) and all HR policy development, interpretation, guidance and oversight.

Overall, the HR programs were in compliance with applicable public laws. Greater standardization and formalization of HR policy and guidance at both campuses with a planned management training program would benefit the Agency.

ADMISSIONS/ELIGIBILITY

Knowledgeable admissions personnel at both AFRH campuses managed their programs in an effective manner. Additionally, highly effective stipend programs at both campuses provided productive activity for involved residents and generated considerable labor cost savings. However, the Agency lacked admissions policy and guidance that established a system of priorities with prescribed rules for determining equitable and consistent standards for eligibility.

FINANCIAL MANAGEMENT/ANALYSIS

Significant progress was evident in the financial management area since the previous triennial inspection. AFRH achieved success in reversing the recent trend of a declining Trust Fund balance. With the implementation of several cost-cutting measures, projected revenues are expected to exceed projected operating expenses by approximately $6 million in FY05.

AFRH transferred their accounting functions to BPD. This move enhanced the Home's ability to comply with required accounting standards and applicable laws, to include the use of a Joint Financial Management Improvement Plan (JFMIP) certified financial management system. However, the inspection team identified oversight deficiencies in the transition of financial functions to BPD that included insufficient accounts receivable reconciliation, deposit verification and inaccuracies in revenue classification. As a result, the Trust Fund balance was inaccurately reported in the FY06 Presidential Budget Submission. Budgetary accounting differences between AFRH and BPD were a contributing factor.

Additionally, several areas for improvement were noted. AFRH lacked audited financial statements for FY03 and FY04. At the time of the inspection, AFRH was on track to have an audit completed for 2005 financial statements. Furthermore, AFRH neither completed an annual Statement of Assurance on management controls nor established a long-term Financial Plan as required by the Chief Financial Officers' Act of 1990. Finally, the Agency and campuses lacked adequate oversight of the Government Purchase Card program.

RECORDS MANAGEMENT

Overall, the Records Management programs at the Agency and both campuses were not managed in an effective manner. In addition, the Freedom of Information Act (FOIA) programs at both campuses and the Privacy Act (PA) program at AFRH-G were deficient and require immediate attention.

INFORMATION TECHNOLOGY

AFRH instituted a number of significant information technology (IT) changes across both campuses and the Agency. At the time of the inspection, all applications, file storage and E-mail services were being migrated to a web-based enterprise architecture. The purpose of the migration was to enhance accessibility to information and services. However, the emphasis on transitioning to a web-based architecture came at the expense of the static infrastructure of both campuses. Clients at both campuses used operating systems that had either ineffective or no security safeguards. Information systems management oversight was lacking. Furthermore, Software Management License programs did not exist at either campus. Overall, AFRH did not comply with Federal Information Systems Management Act (FISMA), Office of Management and Budget (OMB) Circular A-130 and Executive Order 13103 information technology requirements.

Moreover, the campus IT staffs were reduced from three positions to one at AFRH-G and from six positions to two at AFRH-W. AFRH no longer possessed the number of IT personnel required to operate the network as it is currently configured. As a result, segments of the network functioned at speeds that were well below the industry norm. The transition to a web-based enterprise architecture, when completed, will not address the issues identified in this report.

CONTRACTING

AFRH partnered with BPD to provide contracting services for supplies and services. Overall, BPD provided the Agency adequate service IAW the Federal Acquisition Regulation (FAR) and Department of Treasury Acquisition Regulation (DTAR). However, an overall strategic plan for the acquisition of supplies and services and acquisition plans for individual contracts did not exist. Likewise, adequate quality assurance surveillance plans and assurance measures were not in place and contracts were not properly funded. Finally, consistent policy and guidance for contracting officer technical representatives were lacking.

CIVIL ENGINEERING

Agency and campus civil engineering personnel were dedicated, knowledgeable and enthusiastic. Each Campus Operations staff operated in a unique manner. AFRH-W, which is a significantly larger campus, operated with a contract workforce. AFRH-G operated with an in-house workforce. Although both Campus Operations staffs were responsible for identical functions, they did not have common configurations, software or directives. Moreover, at AFRH-W, strategies for maintaining historic buildings and an Energy Conservation program were lacking. Additionally, the AFRH-W Master Plan did not account for all campus facilities and assets.

SECURITY

Both campuses provided adequate security. However, there was little evidence of any formal Agency-level policies or procedural guidance. Both AFRH-G and AFRH-W Security Chiefs were uncertain of the role that the Home's Security Operations Specialist played in their day-to-day efforts to formulate security programs at their respective locations.

SAFETY

Overall, the AFRH-G and AFRG-W Safety Managers administered effective but separate Occupational Safety and Health programs. The programs provided sound surveillance and prompt abatement of identified hazards. While some Americans with Disability Act (ADA) compliance progress was noted at AFRH-G, continued management emphasis was required to ensure ADA compliance remained a top priority. In addition, Risk Management Incident Report coordination, safety training documentation and recreational-related safety deficiencies were noted at both campuses.

MEDICAL

AFRH-G and AFRH-W were more than just retirement communities. Although the campuses provided healthcare, they were unlike the medical treatment facilities routinely visited by any military service's inspection agency. Also, few, if any, civilian counterparts served as useful benchmarks for comparison. To avoid Joint Commission on Accreditation of Healthcare Organizations (JCAHO) redundancy, and to balance the "findings" pointed out in the JCAHO accreditation reports, the inspection team did the following: 1) verified follow-up in key healthcare service areas which JCAHO requested improvement; 2) annotated issues in service opportunity; 3) noted updates and changes made by the facilities; 4) recommended avenues and options for improvement; and, 5) reviewed other non-JCAHO associated aspects involved with potential healthcare sensitivities involved in these special facilities.

JCAHO Quality Reports for AFRH-G (13 October 2005) and AFRH-W (31 January 2006) are included in *Section IV* of this report.

ESTATE MATTERS

Congress first established a home for ill or disabled soldiers in 1851 under, *An Act to found a Military Asylum for the Relief and Support of invalid and disabled Soldiers of the Army of the United State*s. The asylum was funded through appropriations and other means, including "all monies belonging to the estates of deceased soldiers, which are now, or may hereafter be unclaimed for the period of three years…" Today, AFRH still receives unclaimed monies or property from the estate of deceased residents of the Home. Both campuses performed their duties and responsibilities with regards to estate matters in a satisfactory manner.

SERVICES

Enthusiastic, customer-friendly services personnel at AFRH-G and AFRH-W professionally managed the Recreation, Leisure, and Wellness (RLW) programs. The programs provided a wide and creative variety of activities that enhanced residents' morale and kept them active and healthy. Recreation facilities, with few exceptions, were clean, effectively managed, well equipped and safe. While both campuses developed their own standard operating procedures, they lacked standardization. In addition, minimal Agency-level policy and guidance existed.

TABLE OF FINDINGS AND CAUSE CODES

AFRH Findings and Cause Codes Log		
Number	**Findings**	**Cause Code**
A-01	AFRH-W operated without a Director	Manpower
A-02	Some rules for operation of AFRH were not current and lacked standardization between campuses	Oversight
A-03	AFRH-G did not establish and use a Local Board of Trustees	Oversight
A-04	AFRH-W did not use the established Local Board of Trustees	Oversight
C-01	AFRH did not establish a system of priorities for the acceptance of residents	Guidance
C-02	AFRH did not establish prescribed rules to equitably determine eligibility standards for the acceptance of residents	Guidance
D-01	The 30 September 2004 AFRH Trust Fund balance was not accurately portrayed in the FY06 Presidential Budget Submission	Experience
D-02	AFRH did not file audited financial statements for FY03 and FY04	Experience
D-03	AFRH did not establish effective oversight of financial transaction processing	Oversight
D-04	AFRH did not complete an annual Statement of Assurance	Experience
D-05	AFRH did not establish a long-term Financial Plan	Oversight
D-06	AFRH did not establish an effective accounting mechanism for the Residents' Funds	Oversight
D-07	AFRH lacked adequate oversight of the Government Purchase Card program	Training
D-08	AFRH-G lacked adequate oversight of the Government Purchase Card program	Training
D-09	AFRH-W lacked adequate oversight of the Government Purchase Card program	Experience
E-01	The Agency Records Management program did not meet minimum DOD requirements	Guidance
E-02	The AFRH-G Records Management program did not meet minimum DOD requirements	Guidance
E-03	The AFRH-G Privacy Act program did not meet minimum DOD requirements	Training
E-04	The AFRH-G Freedom of Information Act program did not meet minimum public law requirements	Training
E-05	The AFRH-W Records Management program did not meet minimum DOD requirements	Guidance
E-06	The AFRH-W Freedom of Information Act program did not meet minimum public law requirements	Training
F-01	AFRH-G did not establish a Software License Management	Oversight

	program to ensure compliance with Executive Order 13103 requirements	
F-02	AFRH-G did not establish an information systems management oversight function to ensure compliance with FISMA and OMB Circular A-130 requirements	Oversight
F-03	AFRH-W did not establish a Software License Management program to ensure compliance with Executive Order 13103 requirements	Oversight
F-04	AFRH-W did not establish an information systems management oversight function to ensure compliance with FISMA and OMB Circular A-130 requirements	Oversight
G-01	AFRH, working with BPD, did not establish an overall strategic plan to ensure use of a systematic and disciplined approach to achieve effective AFRH acquisition	Oversight
G-02	AFRH, working with BPD, did not establish an acquisition strategy plan for individual contracts	Experience
G-03	AFRH, working with BPD, did not establish and use quality assurance surveillance plans (QASP) for service contracts. Also, they were not performing contract quality assurance actions.	Oversight
G-04	AFRH, working with BPD, did not accomplish annual contractor performance evaluations using the Contractor Performance System (CPS)	Experience
G-05	AFRH, working with BPD, did not use the appropriate clauses on contracts that contained requirements for government furnished property (GFP), government furnished material (GFM) and/or government furnished facilities in the Statement of Work (SOW) and Performance Work Statement (PWS)	Experience
G-06	AFRH, working with BPD, did not ensure consistent Contracting Officer Technical Representative (COTR) policy and guidance	Guidance
G-07	AFRH did not properly fund firm fixed price contracts	Oversight
H-01	AFRH-W did not develop strategies for maintaining cultural resources [historic buildings] and the methods used for compliance	Oversight
H-02	AFRH-W did not maintain an Energy Conservation program	Guidance
I-01	AFRH did not establish formal policy and guidance for baseline campus security standards	Guidance
J-01	AFRH-G facilities had limited disability access	Safety
J-02	AFRH-G mandated OSHA training was not properly managed	Safety
J-03	The AFRH-G pool facility had structural deficiencies	Safety
J-04	The AFRH-G skills craft shop was not in compliance with woodworking Code of Federal Regulations (CFR) requirements	Safety
J-05	The AFRH-G auto hobby shop did not meet U.S. Environmental Protection Agency (EPA) Clean Water Act of 1977 requirements	Equipment

J-06	AFRH-W Risk Management Incident Reporting process and coordination were lacking	Oversight
J-07	AFRH-W natural pond grounds and surrounding structures were not properly maintained	Safety
J-08	AFRH-W golf course did not have a constructed walkway or approved storage location	Safety
L-01	The AFRH-W Chief of Resident Services did not file deceased residents' wills with the proper court	Oversight
M-01	Agency-level standardized policy and guidance for AFRH RLW programs were lacking	Oversight

AFRH Findings by Cause Codes		
Cause Code	**Number of Finding**	**Percentage**
Oversight	17	38%
Experience	7	16%
Guidance	8	18%
Training	5	11%
Equipment	1	2%
Manpower	1	2%
Safety	6	13%
Security	0	0%
Other	0	0%
Total Number of Findings	45	100%

SECTION II – INSPECTION RESULTS

TAB A – SENIOR MANAGEMENT

OVERALL ASSESSMENT

The Armed Forces Retirement Home (AFRH) senior management assessment addressed program management required under 24 U.S.C. § 415 - 417. These sections covered Chief Operating Officer (COO) qualifications, duties and responsibilities, Local Boards of Trustees, and local leadership of each AFRH campus.

AFRH evolved significantly over the last three years and senior management made great strides to effect positive change across the Agency and campus structure. However, in the past year, progress was impeded due to either a transition in or lack of senior leadership at both campuses. The absence of an Armed Forces Retirement Home-Washington Director created a void in day-to-day leadership at that site.

Recently established partnerships with public and private agencies were force enablers for AFRH. AFRH benefited from economies that were not possible prior to the partnerships. However, senior leadership emphasis was required to continue establishing effective internal controls to ensure that AFRH received agreed upon services.

AFRH personnel provided quality services and support to the residents. At all levels, employees exhibited professional and caring attitudes. Residents and staff interacted in a positive manner. However, gaps in staff communications were noted. Often employees were not sure or aware of proper policy and procedures, forcing the inspection team to go to Agency-level personnel for clarification. At times, only the COO and/or Chief Financial Officer (CFO) could answer questions.

Contributing to the communications issues identified above was the current status of AFRH policy and guidance. As a whole, the Home's policy and guidance were out-of-date. In part, this was attributable to recent organizational changes; however, in several cases, policy and guidance were not updated in several years. This contributed to employees relying on draft written guidance and, in some cases, unwritten guidance or word of mouth.

The failure to use Local Boards of Trustees as required by legislation was a significant management issue. Since the previous triennial inspection, the Local Boards met infrequently. According to the COO and CFO, when the role of the Local Boards changed from a governing to an advisory body, the transition proved difficult.

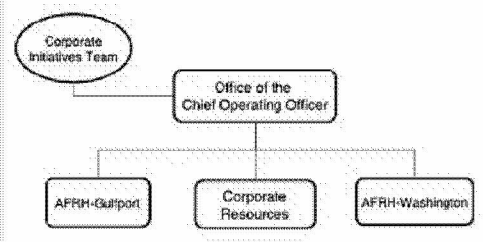
AGENCY

AFRH was an independent establishment in the executive branch of the government. 24 U.S.C. § 411 re-designated The United States Soldiers' and Airman's Home and the Naval Home to the Armed Forces Retirement Home – Gulfport (AFRH-G) and Washington (AFRH-W) respectively. The purpose of the retirement home was to provide residences and related services for certain retired and former members of the Armed Forces.

Agency oversight of AFRH-G and AFRH-W was provided by the COO and his staff who worked out of the Washington DC campus. The COO was subject to the authority, direction and control of the Secretary of Defense. In a 20 March 2003 memorandum, the Secretary delegated the authority and assigned the duties regarding AFRH to the Deputy Undersecretary of Defense for Personnel and Readiness. The Agency staff were administratively determined, excepted service employees IAW 24 U.S.C. § 415(e).

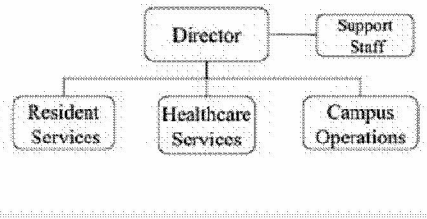
Under the leadership of the COO AFRH developed a "one model" approach to operating each of the campuses. According to the COO, this approach focused on "one agency, two campuses…operating under one set of standards." Over the past two years, the Agency and campus organizational structure evolved in an effort to provide the most efficient and effective management of AFRH. Following AFRH fiscal and manpower reviews, the Agency significantly downsized the workforce at both campuses. The Agency's corporate resources staff provided limited support services to the campuses.

Agency Organization Chart



Agency oversight for the Gulfport and Washington campuses of AFRH is conducted by the Chief Operating Officer.

Campus Organization Chart



Under AFRH's "one model" approach, both homes use the same organizational structure to ensure accountability, service excellence, and standardized operating procedures.

AFRH partnered with outside public and private entities to provide availability of human resources management, financial management/analysis and contracting support services. This, in theory, allowed AFRH to concentrate on their core business - *running the premier retirement community for America's veterans.* AFRH also established support agreements with other DOD entities. AFRH used these agreements (written and verbal) to support operations in areas where

the Home did not possess functional expertise. However, these practices resulted in some internal control deficiencies and fragmented functions and/or missions.

The significant organizational changes outlined above impacted operations, employees and residents. Additionally, solid lines of communications were needed to ensure all parties were kept involved in the change process. However, in the past year, the absence of an AFRH-W Director, coupled with the turnover of both the AFRH-G Director and Deputy Director, effectively removed a key level of leadership and stressed internal communications. The resulting turbulence required the COO and CFO to provide oversight of day-to-day campus operations. Additionally, the Local Boards of Trustees met infrequently since the previous triennial inspection. Congress directed that the Local Boards serve in an advisory capacity. In the past, the boards were a voice to the residents and outside experts that helped facilitate effective communications. (24 U.S.C. § 415(c)(3)(d))

The operation of AFRH was hampered by a lack of current policy and guidance. Pursuant to 24 U.S.C. § 415(c)(3), the COO was charged with the development, issuance and ensuring compliance with appropriate rules for the Agency. According to the Agency's one model approach, AFRH was working to establish one agency with different locations governed by one set of standards, policies and procedures. However, the current lack of policy and guidance impacted operations at the Agency and campus level. The combined effect of the leadership issues discussed earlier and significant operational and personnel restructuring left most of the policy and guidance out-of-date. These factors significantly contributed to a lack of understanding of current procedures and proposed future plans.

The Local Boards of Trustees were not used at either campus. Between 1991 and 2001, AFRH was managed by the Armed Forces Retirement Home Board under Public Law 101-510, § 1515. The law established Local Boards at each facility to provide management oversight to the individual campuses. In 2001, Public Law 107-107, § 416 modified the management structure of AFRH. This law established the COO position and changed the function of the boards from governing to advisory. As stated above, the Local Boards of Trustees met infrequently following the previous triennial inspection. In fact, no board meetings were conducted at either campus in the 16-month period prior to the inspection.

Prior to 17 June 2005, AFRH did not have an Inspector General (IG). In a 17 June 2005 memorandum, the COO appointed the CFO as the agency IG and the agency Chief of Support Services as the Deputy IG. He also established an AFRH hotline number to report allegations of waste, fraud, abuse and mismanagement.

Findings and Actions Required

***(A-01 Finding):** AFRH-W operated without a Director.

Finding Cause Code: Manpower

Observations: The previous AFRH-W director [Army colonel] retired in the fall of 2004. According to the COO, he had actively pursued hiring a civilian director. The absence of an AFRH-W Director resulted in the COO and CFO becoming directly involved in day-to-day campus operations.

Actions Required: Work with OSD to select an active duty officer or hire a civilian director IAW 24 U.S.C. § 417(b)(1) - (3).

***(A-02 Finding):** Some rules for operation of AFRH were not current and lacked standardization between campuses.

Finding Cause Code: Oversight

Observations: AFRH-G and AFRH-W operated under separate policy and guidance in some cases. In addition, at the time of the inspection, the majority of policy and guidance used by the campuses were either in draft or out-of-date. Several employees were unclear as to which version of an operating instruction they should use. In some areas, employees referred to AFRH-W guidance for one answer and AFRH-G guidance for another. In other areas, they followed unwritten rules which were different from written policy. The Chief of Support Services worked to update policy and guidance; however, the Agency did not inform personnel, through interim guidance, what the current policies and procedural guidance were.

Actions Required: Perform a comprehensive review of the current status of all policy and guidance to include forms. Develop interim guidance where necessary to provide adequate clarification. Finally, develop standardized Agency-level policy and guidance and allow campuses to supplement the guidance to accommodate local requirements IAW 24 U.S.C. § 415(c)(3)(A).

Recommendations

(AR-01 Recommendation): AFRH establish a Memorandum of Agreement (MOA) with the DOD Inspector General to provide IG services to AFRH. According to 24 U.S.C. § 411(f), "The Secretary of Defense may make available from the Department of Defense to the Retirement Home, on a non-reimbursable basis…access to investigative facilities of the Inspector General of the Department of Defense…support necessary to enable the Retirement Home to carry out its functions…." Recently, AFRH established an IG and Deputy IG position. However, the creation of these positions placed additional requirements on the Home's already limited administrative staff. In addition, the Home's IG construct conflicted with guidance provided under *Quality Standards for Federal Offices of Inspector General*. In particular, the CFO did not have the appearance of objectivity or independence as outlined in Section II, A and C.

(AR-02 Recommendation): AFRH work with OSD to identify what type of legal and other support services are required by AFRH and available from DOD components. If possible, acquire these services on a non-reimbursement basis IAW 24 U.S.C. § 411(f). AFRH had an outdated MOA with the 11th Wing Staff Judge Advocate, Bolling Air Force Base, Washington DC to provide legal services to the Home. It was established on 15 March 1996 and had expired on 14 March 2002.

AFRH – GULFPORT

Recent personnel challenges at the senior level were evident at AFRH-G campus. The previous Director [Navy captain] was on terminal leave and scheduled to retire in the fall of 2005. The Deputy Director position was also vacant; the Deputy [Air Force lieutenant colonel] was reassigned for administrative purpose. In addition, the Associate Director [active duty Navy command master chief] reported for duty in May 2005. At the time of the inspection, the Associate Director was learning his position responsibilities and the unique requirements associated with AFRH operations. AFRH senior leadership and AFRH-G personnel worked diligently to deal with the turmoil associated with the leadership turnover. In May 2005, the CFO was appointed as the interim Director; however, he was not available during the inspection. Since May 2005, his time had been split between AFRH-G and AFRH, which required him to serve as both the CFO and the interim director. The COO was present during the inspection and able to address director-related issues. In addition, he appointed an interim Deputy Director from the campus staff who was available and responsible for the day-to-day management of the facility.

Historically, AFRH-G appointed either an active duty/retired officer or a general service employee to oversee the retirement home operations. Previous military Directors had varying service experiences; however, none of these individuals possessed experience in managing retirement home facilities. Recently, the COO selected a civilian [excepted service] to serve as the AFRFH-G Director; he was scheduled to assume his duties in August 2005. The newly selected Director had 15 years experience in health care management to include administrator, multi-facility management and corporate operations related to assisted living, long-term care, dementia and Joint Commission on Accreditation for Healthcare Organizations (JACHO) accreditation procedures.

The Local Board of Trustees was not being used at AFRH-G. Since the previous triennial inspection, the Local Board met only three times: 22-23 October 2002, 8 January 2003 (via teleconference), and 3 March 2004.

According to the 22-23 October 2002 meeting minutes, the board was scheduled to meet quarterly. AFRH-G personnel stated that AFRH was responsible for scheduling Local Board meetings and establishing the agenda. During the inspection, the COO was asked why the Local Boards had not met in over a year. The COO responded that AFRH experienced difficulty with the boards and their advisory role and responsibility. In his opinion the board had not adjusted to

functioning in an advisory capacity and he believed that committees would be better suited to provide the advice that the AFRH leadership needed. According to the 3 March 2004 board meeting minutes, the COO stated "…the structure of the board has changed from a governing board to an advisory board and OSD had given a verbal nod to introduce committees." At the time, the COO recommended forming Resident Care, Marketing, Investing, Asset Management Planning and Volunteerism Committees. However, at the time of the inspection, only the Resident Care Committee was established and no record of meetings was documented. According to the COO and interim Deputy Director, they were planning to conduct a Local Board meeting in the fall of 2005. The interim Deputy Director stated AFRH-Gulfport did not have a current list of board members and he was unaware of the current status of members.

Findings and Actions Required

***(A-03 Finding):** AFRH-G did not establish and use a Local Board of Trustees.

Finding Cause Code: Oversight

Observations: The requirement for the AFRH-G Local Board of Trustees was not met. A Local Board of Trustees met only twice since the 22-23 October 2002 meeting. Prior to this time, the intent was to hold these meetings quarterly. No documentary evidence was available to show that AFRH-G attempted to schedule any meetings other than those mentioned earlier or that a Local Board of Trustees was appointed IAW 24 U.S.C. § 416. Comments made by senior AFRH leadership indicated that it was the intent of AFRH-G not to hold any board meetings, but work to establish committees in lieu of the board. They stated that this would serve their needs best as they transitioned AFRH-G and refocused on the mission of providing resident-centered services in a quality community setting. However, leadership was aware of the Local Board of Trustees requirement and they stated that they were working to schedule a meeting in the fall of 2005.

Actions Required: Work with OSD to either establish a Local Board of Trustees as required by 24 U.S.C. § 416 or seek legislative relief to modify the current public law board requirements. Per 24 U.S.C. § 416(b), the Local Board shall serve in an advisory capacity to the Director of the Facility and the COO. The board shall consist of at least 11 members and shall be appointed by the SECDEF in consultation with each of the Secretaries of the concerned military departments. The board composition shall comply with the requirements of 24 U.S.C. § 416(c)(1)(a) - (l).

AFRH – WASHINGTON

Recent personnel challenges at the senior level were also evident at AFRH-W campus. The previous Director [Army colonel] retired in the fall of 2004. Recently, the Deputy Director [Navy commander] transferred for a normally scheduled duty rotation. In the weeks before the inspection, the new Deputy Director reported for duty and was still learning his position responsibilities and the unique requirements associated with AFRH operations. The Associate Director position, called Ombudsman at AFRH-W, was filled by a retired Army sergeant major

[E-9]. Prior to his retirement, the AFRH-G Director was also the acting director for AFRH-W. However, AFRH-W did not have a full-time director for the past year. The inspection team viewed this as problematic and resulted in the COO and CFO becoming directly involved in day-to-day campus operations.

Historically, AFRH-W, like AFRH-G, appointed either an active duty/retired officer or a civil service employee to oversee the retirement home operations. Previous military Directors had varying service experiences; however, none of these individuals possessed experience in managing retirement home facilities. According to the COO, he was searching for a civilian [excepted service] qualified in retirement home management, as was done at AFRH-G.

The Local Board of Trustees was not being used; however, documentation showed that one was established. The CFO stated that the Agency wanted to work to establish one board for both campuses versus a Local Board at each facility. The CFO thought this would provide an agency-wide perspective as opposed to a campus specific perspective.

According to available documentation, AFRH-W conducted only three Board meetings since the previous triennial inspection. The Local Board met on 19 December 2002, 19 June 2003, and 29 January 2004. It was noted, in a draft schedule for the last board meeting that someone penciled in 'delete' next to committee meetings. The Resident Life, Fiscal Matters and Healthcare Matters Committees were scheduled to meet with the Local Board. The final agenda for the January 2004 board meeting did not include the committee meetings.

Findings and Actions Required

***(A-04 Finding):** AFRH-W did not use the established Local Board of Trustees.

Finding Cause Code: Oversight

Observations: The requirement for the AFRH-W Local Board of Trustees was not met. A Local Board of Trustees did not meet since the 29 January 2004 meeting. No documentary evidence was available to show that AFRH-W attempted to schedule any meetings other than those mentioned above. The CFO indicated that it was the intent of AFRH-W not to hold Local Board meetings, but to work to establish an Agency-level board in lieu of the Local Board.

Actions Required: Either use the Local Board of Trustees IAW 24 U.S.C. § 416 requirements or work with OSD to seek legislative relief to modify the current public law board requirements. Per 24 U.S.C. § 415(c)(2), the COO shall supervise the operation of the Local Board of those facilities.

TAB B – HUMAN RESOURCES MANAGEMENT

OVERALL ASSESSMENT

The AFRH human resources (HR) assessment addressed administration and oversight of human resources programs, including staffing, classification, employee relations, labor relations and advisory personnel services. Overall, these programs were in compliance with applicable public laws. Greater standardization and formalization of HR policy and guidance at both campuses with a planned management training program would benefit the Agency.

During the past year, significant change occurred in the way HR services were provided to appropriated fund employees within the Agency and at the Gulfport and Washington campuses. Starting October 2004, all HR services for both campuses, except employee benefits, were franchised to the Bureau of Public Debt (BPD), Parkersburg, WV. Three HR positions remained on the Agency staff to provide employee benefits services (i.e., retirements, health and life insurance) and all HR policy development, interpretation, guidance and oversight.

AFRH-G and AFRH-W each maintained a separate employee appraisal system rating scale and annual appraisal schedule. AFRH-G's system featured a five-tier rating appraisal with an annual 30 June closeout. AFRH-W's system featured a four-tier rating appraisal with a annual closeout on the employee's hire date anniversary. In January 2004, employees at both campuses received a close-out appraisal under their old appraisal system. At the same time, each employee was given the performance standards to be used in ratings under the new appraisal system. With the assistance of a contractor, AFRH formulated new employee performance standards for use in the new appraisal system. These performance standards cross-referenced a specific AFRH Business Plan objective. This new appraisal system featured a four-tier rating scale with an annual 30 June closeout. The initial rating cycle under this new system ended 30 Jun 2005.

AGENCY

An AFRH Performance Management and Performance Awards Review Board was established to review all AFRH employee proposed ratings and awards beginning 30 June 2005 and for each subsequent rating cycle. The Board Charter was established on 27 June 2005 and named the COO, CFO, Chief Support Services and both campus Directors as members. The Board was tasked with providing program oversight to ensure equity of ratings and awards distribution across AFRH.

During a review of the official Position Description (PD) file at BPD, it was discovered that several of the AFRH PDs were not on file. Further discussion with the BPD staff indicated that in the transition to assume servicing of AFRH not all PDs had been received. Recently, the individual that had been reconciling the files had departed BPD.

A review of 19 disciplinary action case files at BPD showed good background documentation to support the initial proposed action. However, several files remained open pending documentation to support the final disciplinary action decision. In some of the open files, the employee's Official Personnel Folders (OPF) had documentation of the final decision. However, support documents for that decision were not in the disciplinary case file. In most case files, the actual management disciplinary action proposal or decision memos were not signed by the management official. Their name was simply typed at the top of the memo.

A review of staffing folders at BPD revealed well organized and complete files. The files allowed the inspector to easily follow the staffing process from announcement through the final selection or cancellation of the action. Only two minor administrative deficiencies were noted. In one case an applicant was notified he was "outside the area of consideration" when he was actually "not qualified." The second case involved a nurse direct hire action at AFRH-G and the file did not contain the documentation to verify the selectee's current nursing certification. BPD took immediate action to obtain a copy of the license from AFRH-G.

BPD staff personnel stated that they had not finished screening all employee OPFs since taking on HR servicing of AFRH. One OPF contained documentation of a suspension that was rescinded. Staff personnel immediately removed the suspension documents from the OPF. Another folder had documentation of a return to duty from a five-day suspension action with a conflicting remark included. Again, staff personnel immediately began action to correct the remark.

The AFRH Equal Employment & Opportunity (EEO) program was administered by BPD for the past year. Discussions with the BPD EEO office indicated that while they intended to travel to both AFRH campuses to train and discuss EEO issues, this did not occur. Recently, the program responsibilities were scheduled to return to AFRH beginning 1 October 2005. Recruitment of an EEO Manager was under way. The EEO Manager will have direct access to the COO and both campus Directors. Only minimal documentation existed to indicate active assessments of EEO trends or statistics.

Management officials, particularly those at AFRH-G, voiced a concern with the new performance plan templates that reference employee performance relative to meeting AFRH Business Plan objectives. Their specific concern was that the performance plan did not address job specific technical performance requirements for the employee. The Agency HR staff indicated that the local manager had the flexibility to add technical job specific performance standards to the Business Plan template performance standards.

A deficiency was noted in the recording of official time for union representatives who performed representational activities. When asked how the official time hours were determined for the FY 2004 report, Agency HR personnel responded that they contacted the union for input. Tracking "official time" for union representational duties is the responsibility of management. Official time must be tracked in four categories: Term Negotiations, Mid-Term Negotiations, Dispute

Resolution or General Labor Relations Activities. The BPD Payroll representative indicated that the Standard Time and Reporting System (STARS) which was used by AFRH did provide coding capabilities for each of the four categories of official time to be tracked.

The needed revision of the 1989 AFRH Employee Handbook, recommended in the previous AFRH Triennial Inspection report, had not been completed. BPD maintained an employee orientation web site, http://arc.publicdebt.treas.gov/DWP/fs/fsafrhorientation.htm. Together with the Office of Personnel Management (OPM) web site www.OPM.gov, a significant amount of HR information was readily available for employees.

The Agency HR staff indicated that for several HR programs, a Naval Home policy existed at the AFRH-G campus and a Soldiers' and Airman's policy existed at the AFRH-W campus. The policies were similar, but with variations. For consistency and ability to compare program application across both campuses, creating a standardized and formal AFRH policy would make it easier to administer and manage HR programs. In addition, it would minimize cross campus inconsistencies.

Findings and Actions Required

None noted.

Recommendations

(BR-01 Recommendation): AFRH senior leadership develop and publish an Agency-level directive to standardize the HR management program for both campuses.

(BR-02 Recommendation): Agency HR staff work with AFRH managers and BPD staff to ensure managers complete official disciplinary action files (background, proposed action, employee reply, *Douglas* factors and final decision).

(BR-03 Recommendation): Agency HR staff establish and use a policy requiring disciplinary action proposing and deciding officials to sign proposal and decision memos. This would enable the staff to authenticate the validity of disciplinary and adverse action proposal and decision memos for use in subsequent appeal or grievance actions.

(BR-04 Recommendation): Agency HR staff train AFRH managers to ensure awareness of their flexibility to add individual job specific technical performance standards to the Business Plan template performance standards.

(BR-05 Recommendation): Agency HR staff train AFRH managers to ensure awareness of their responsibility to properly document use of "official time" in STARS using the appropriate code to designate which of the four representational categories is appropriate for each

occurrence. A copy of the four official time category codes for use in STARS was provided to the Agency HR staff.

(BR-06 Recommendation): Agency HR staff establish and place their employee handbook on the AFRH website www.AFRH.gov with links to the OPM, BPD, Thrift Savings Plan (TSP) and other appropriate web sites. Place campus unique HR information on this site.

(BR-07 Recommendation): Agency HR staff work with BPD to determine which PDs are missing from the BPD file and with AFRH managers to reconcile the file.

AFRH – GULFPORT

During the past year, dramatic changes occurred in AFRH HR servicing. In addition to the majority of HR functions being franchised to BPD in October 2004, the one HR liaison position at the Gulfport campus was eliminated when the individual retired in November 2004. Employees and managers had to deal long distance with either the Agency HR staff for benefits issues or BPD for other HR issues. A listing of the BPD point of contact for specific HR issues was provided to employees. During the inspection, concerns were raised regarding employee access to make long distance calls to the Agency HR and BPD offices. At times, employee issues were personal and the employee did not want the supervisor to know about the HR contact.

Recently, the workforce was significantly downsized following an AFRH fiscal and manpower review. The resulting Reduction in Force (RIF) caused involuntary separations, movement of employees into different positions, and realigning and consolidating of duties from several positions into fewer remaining positions.

The employee focus group discussion identified stress and frustration over the recent changes. Several employees indicated a perception that duties from eliminated higher grade positions were realigned to them without any upgrade of their position. Employees who had dealt with the BPD staff for HR issues stated the staff was very knowledgeable. They indicated they received good advice and service from the BPD HR staff. However, they did express a degree of frustration when having to leave a message and wait for a response.

The manager focus group discussion indicated that managers were very pleased with the service being provided by BPD, even though they missed the face-to-face contact previously available with the AFRH-G HR liaison.

Discussion with a local labor representative indicated few labor issues or grievances at the AFRH-G campus. Typically, employee issues were resolved informally. The AFRH-G campus was without a local labor agreement for several years and contract negotiations were ongoing. According to the representative, the union felt that management had been less than responsive in

their efforts to complete the negotiations. Finally, the representative voiced significant concern over the recent RIF and the elimination of the AFRH-G HR liaison position.

Area of Strength

A review of managers' employee folders showed that the new AFRH Business Plan templates for performance standards were implemented. Additionally, managers and employees signed off acknowledging that employees were made aware of their performance standards.

Findings and Actions Required

None noted.

Recommendations

(BR-08 Recommendation): AFRH-G review campus bulletin boards to eliminate expired HR information and replace outdated documents with updated material.

(BR-09 Recommendation): AFRH-G assess the need for toll free telephone arrangements for employees to contact either the BPD or AFRH HR office.

AFRH – WASHINGTON

During the past year, dramatic changes also occurred in AFRH HR servicing. The majority of HR functions were franchised to BPD in October 2004. Employees and managers had to deal long distance with BPD on all HR issues other than benefits. A listing of the BPD POC for specific HR issues was provided to employees.

Recently, the workforce was significantly downsized following an AFRH fiscal and manpower review. The resulting RIF caused involuntary separations, movement of employees into different positions, and realigning and consolidating of duties from several positions into fewer remaining positions.

The employee focus group discussion identified significant stress and frustration in the workforce over the recent reductions and duty realignments. A common concern was the perception that higher grade duties were realigned to lower graded positions without an upgrade to the new position. The employees felt that their position descriptions were written for grade control and not for accuracy of defining duties. They expressed a degree of frustration over the delays associated with working HR issues with BPD rather than with a local HR individual.

The manager focus group discussion indicated that managers were apprehensive about the AFRH Performance Management and Performance Awards Board role in the new appraisal system.

High turnover and recruitment issues, especially in the nursing field, were voiced. Managers generally expressed satisfaction with the level of HR service provided by BPD.

A representative of Laborer's International Union of North America (LIUNA) Local 572 stated that they had a very good working relationship with management at the Washington campus. A representative of the American Federation of Government Employees (AFGE) Local 3090 was not available.

Findings and Actions Required

None noted.

Recommendation

(BR-10 Recommendation): AFRH-W conduct a thorough review of the turnover and recruitment issues in nursing and other hard to recruit areas. Consider using available recruitment and retention alternatives including recruitment, retention or relocation bonuses and first duty station moves.

TAB C – ADMISSIONS/ELIGIBILITY

OVERALL ASSESSMENT

The AFRH admissions/eligibility assessment addressed resident eligibility standards and priority system to ensure compliance with 24 U.S.C. § 412. Overall, knowledgeable admissions personnel at both AFRH campuses managed their programs in an effective manner. However, AFRH lacked policy and guidance that established a system of priorities with prescribed rules for determining equitable and consistent standards for eligibility.

The AFRH stipend program was also assessed to ensure compliance with 24 U.S.C. § 421. Highly effective stipend programs at both AFRH campuses provided productive activity for involved residents and generated considerable labor cost savings.

AGENCY

Public affairs and marketing personnel managed the admissions program at the Agency level. As of May 2005, applications to AFRH were submitted through that office. Prior to this time, applications were accepted at each AFRH campus. Once all application items were received including campus preference, the application was forwarded to the perspective campus, which conducted medical and eligibility reviews. Upon completion of the reviews, public affairs and marketing personnel contacted the applicant with an admissions decision. If accepted and there was no immediate availability at the requested campus, the applicant was added to a waiting list. Once a room became available, the applicant was notified and their record was sent to the campus to aid in the admissions process. The resident admission record was then kept at the gaining campus.

Public affairs and marketing personnel maintained the waiting list which was prioritized by application approval date. This priority process was not documented. In addition, no established AFRH policy and guidance for setting acceptance priorities existed as required by 24 U.S.C. § 412(d). While AFRH had a draft *AFRH Resident Eligibility Prioritization Plan*, it lacked sufficient detail that addressed use of the waiting list and how the most deserving applicants would be accepted.

During the admission process, campus personnel reviewed eligibility standards. However, a lack of documentation in accepted application records was noted at both campuses. Each of the four eligibility categories defined in 24 U.S.C. § 412(a)(2) - (4) had two or three sub-criteria eligibility factors. In most cases, documentation did not exist to show that all sub-criteria factors were used to determine eligibility. For example, Eligibility Category 2 required that persons be incapable of earning a livelihood because of a service-connected disability incurred in the line of duty. While the service-connected disability was documented, no documentation existed to show the person was incapable of earning a livelihood.

Additionally, no AFRH policy and guidance (prescribed rules) existed to direct the review of the eligibility category sub-criteria requirements mentioned above. Title 24 U.S.C. § 412(d) directed the COO to determine prescribed rules for each eligibility category. Without prescribed rules, it could not be determined whether those sub-criteria eligibility requirements were reviewed or considered in a consistent and equitable manner.

A review of denied applications revealed that denials were consistently based on applicants' failure to meet eligibility criteria outlined in 24 U.S.C. § 412. However, denied applications due to felony convictions were only identified when the applicant indicated it on the application as requested. The admission process did not include a background check to ensure applicants had not been convicted of a felony.

Area of Strength

Denied applications were all denied for just reasons as prescribed by 24 U.S.C. § 412.

Findings and Actions Required

***(C-01 Finding):** AFRH did not establish a system of priorities for the acceptance of residents.

Finding Cause Code: Guidance

Observations: 24 U.S.C. § 412(d) stated "The Chief Operating Officer shall establish a system of priorities for the acceptance of residents so that the most deserving applicants will be accepted whenever the number of eligible applicants is greater then the Retirement Home can accommodate." AFRH used a waiting list that prioritized applicants by the date of application approval for acceptance of residents. This process was not documented in any AFRH policy or guidance. According to the COO, the current process was "fair and equitable" due to the fact that the AFRH-W campus had capacity to accommodate additional residents. While AFRH had a draft *AFRH Resident Eligibility Prioritization Plan*, it lacked sufficient detail.

Actions Required: IAW 24 U.S.C. § 412, COO establish AFRH policy and guidance that establishes a system of priorities so that the most deserving applicants are accepted when either AFRH campus exceeds the number of eligible applicants it can accommodate. It should describe when and how these waiting lists will be executed.

***(C-02 Finding):** AFRH did not establish prescribed rules to equitably determine eligibility standards for the acceptance of residents.

Finding Cause Code: Guidance

Observations: 24 U.S.C. § 412 required prescribed rules for eligibility categories as outlined below. The COO did not establish rules.

Eligibility Category 2: "Persons who are determined under rules prescribed by the Chief Operating Officer to be incapable of earning a livelihood because of a service-connected disability incurred in the line of duty in the Armed Forces." 24 U.S.C. § 412(a)(2)

Eligibility Category 3, sub-criteria (C): "… are determined under rules prescribed by the Chief Operating Officer to be incapable of earning a livelihood because of injuries, disease, or disability." 24 U.S.C. § 412(a)(3)

Eligibility Category 4, sub-criteria (B): "… are determined under rules prescribed by the Chief Operating Officer to be eligible for admission because of compelling personal circumstances." 24 U.S.C. § 412(a)(4)

Actions Required: IAW 24 U.S.C. § 412, COO establish prescribed rules through formal policy and guidance to determine resident eligibility.

Recommendations

(CR-01 Recommendation): AFRH standardize records by using record folder tabs and standardized forms. Resident record folders were not well organized; tabs were not used to separate eligibility information from application and resident activity information. Also, different forms were used to capture the same data.

(CR-02 Recommendation): AFRH conduct background check on applicant to ensure eligibility requirements are met as prescribed by 24 U.S.C. § 412.

AFRH – GULFPORT

Admissions/Eligibility: As of 14 July 2005, AFRH-G had the capacity for 604 residents and maintained an overall capacity rate of 96 percent with 578 residents residing at the facility. Resident living quarters included independent living, assisted living and nursing care. The campus did keep some assisted living and nursing care beds available for eventual transition of their assisted living residents to these facilities. The independent living quarters, even though at maximum capacity, showed a less than 100 percent capacity rate due to rooms not being occupied during maintenance and preparation. The campus had a waiting list of approximately 100 applicants. Applicants on the waiting list were given the option to enter the AFRH-W campus. Declining this option did not impact their priority on the AFRH-G waiting list.

As mentioned in the Agency section, once the prospective application package was completed, it was forwarded to the Gulfport campus for the medical and eligibility review and approval. The eligibility requirements were verified through attached records and/or the applicant was contacted to provide additional supporting documentation. In most cases, only one sub-criteria eligibility requirement was documented as having been confirmed. The AFRH-G interim

Deputy Director stated that some of the sub-criteria requirements were not documented due to "common sense reasoning." However, no AFRH policy and guidance to prescribe rules for determining these sub-criteria eligibility requirements existed as required by 24 U.S.C. § 412.

Stipends: The AFRH-G stipend program was well managed and documented. The Gulfport campus had approximately 150 residents that received a stipend. The program addressed all 24 U.S.C. § 421 requirements. Each stipend compensated volunteer was limited to earning $120 per month. This robust program saved AFRH money by staffing positions with residents versus hires at the local economy rate. More importantly, the program provided residents a productive activity promoting health and social welfare.

Area of Strength

The AFRH-G stipend program was managed in a highly effective manner resulting in savings to the campus versus hiring personnel off the local economy to do the same jobs at the higher local rates. It also provided a productive activity promoting health and social welfare.

Findings and Actions Required

None noted.

AFRH – WASHINGTON

Admissions/Eligibility: As of 21 July 2005, AFRH-W had the capacity for 1,261 residents and maintained an overall capacity rate of 79 percent with 997 residents residing at the facility. Resident living quarters included independent living, assisted living and nursing care. The campus did keep some assisted living and nursing care beds available for eventual transition of their assisted living residents to these facilities. This campus did not have a waiting list.

As mentioned in the Agency section, once the prospective application package was completed, it was forwarded to the Washington campus for the medical and eligibility review and approval. The eligibility requirements were verified through attached records and/or the applicant was contacted to provide additional supporting documentation. In most cases, only one sub-criteria eligibility requirement was documented as having been confirmed. No AFRH policy and guidance to prescribe rules for determining these sub-criteria eligibility requirements existed as required by 24 U.S.C. § 412(a)(2) - (4).

Stipends: The AFRH-W stipend program was well managed and documented. The Washington campus had approximately 130 residents that received a stipend. The program addressed all 24 U.S.C. § 421 requirements. Each stipend compensated volunteer was limited to earning $120 per month. This robust program saved AFRH money by staffing positions with residents versus hires at the local economy rate. More importantly, the program provided residents a productive activity promoting health and social welfare.

Area of Strength

The AFRH-W stipend program was managed in a highly effective manner resulting in savings to the campus verses hiring personnel off the local economy to do the same jobs at the higher local rates. It also provided a productive activity promoting health and social welfare.

Findings and Actions Required

None noted.

TAB D – FINANCIAL MANAGEMENT/ANALYSIS

OVERALL ASSESSMENT

Significant progress was evident in the financial management area since the previous triennial inspection. AFRH achieved success in reversing the recent trend of a declining Trust Fund balance. With the implementation of several cost-cutting measures, projected revenues were expected to exceed projected operating expenses by approximately $6 million in FY05.

In April 2004, AFRH transferred their accounting functions to the Bureau of Public Debt (BPD). This move enhanced the Home's ability to comply with required accounting standards and applicable laws, to include the use of a Joint Financial Management Improvement Plan (JFMIP) certified financial management system. However, the inspection team identified oversight deficiencies in the transition of financial functions to BPD that included insufficient accounts receivable reconciliation, deposit verification and inaccuracies in revenue classification. As a result, the Trust Fund balance was inaccurately reported in the FY06 Presidential Budget Submission. Budgetary accounting differences between AFRH and BPD were a contributing factor.

Additionally, several areas for improvement were noted. AFRH lacked audited financial statements for FY03 and FY04. Although a contract was awarded to Brown & Company to perform the 2004 audit, a miscommunication occurred and the audit was not performed. At the time of the inspection, AFRH was on track to have an audit completed for 2005 financial statements. Furthermore, AFRH neither completed an annual Statement of Assurance on management controls nor established a long-term Financial Plan as required by the Chief Financial Officers' Act of 1990. Finally, the Agency and campuses lacked adequate oversight of the Government Purchase Card program.

AGENCY

The 1991 National Defense Authorization Act created the AFRH Trust Fund to finance operations and capital projects. The Agency received revenues from the following sources: payroll deduction of 50 cents per month from active duty enlisted, warrant and limited duty officer personnel; resident fees; fines and forfeitures from military courts; interest on fund investments; and donations.

In April 2004, AFRH outsourced their accounting function to the BPD Administrative Resource Center (ARC). This enhanced the ability of AFRH to comply with required accounting functions and applicable laws. As a result of this outsourcing, AFRH obtained the Oracle Federal Financials accounting system, which was JFMIP certified. AFRH also implemented a property management system with the ARC and migrated to e-Travel, both of which were integrated with the financial accounting system. Under its outsourcing arrangement with BPD, individual managers easily accessed financial reports to monitor their budgets.

The AFRH Trust Fund balance increased from $97.3 million (31 March 2002) to $118 million (30 September 2004). However, the Trust Fund remained significantly below the $171.2 million balance at the end of FY92. In addition, AFRH reduced its budget appropriation request from $71 million in FY02 to $58 million for FY06. Due to an active cost containment program, the AFRH's revenues exceeded costs on an operating basis (excluding long-term capital outlays). Based on a review of the financial statements for the 9-month period ending 30 June 2005, the inspection team projected that revenues would exceed the Home's costs by approximately $6 million (annualized).

In 1995, Congress passed legislation under the National Defense Authorization Act authorizing an increase generated by payroll deduction from enlisted, warrant officer and limited duty officer service members from 50 cents to $1.00. To date, the authorization to increase the payroll deduction was not implemented. The Trust Fund lost approximately $7 million (based upon FY04 end strength) plus interest for each year the authorization was not implemented or approximately $65 million since FY95 (FY96 - FY04).

AFRH did not submit to Congress a five-year financial management plan as required by the Chief Financial Officers' Act of 1990.

Although Congress did not appropriate funding for AFRH they authorized annual spending limits to operate and maintain AFRH and funds for capital outlays. The operating and maintenance portion of the AFRH budget was governed by the principles of Operations and Maintenance (O&M) funding. However, funding for capital improvements remained available until expended for the completion of capital projects. The AFRH Trust Fund Budget for FY05 was $61 million, of which $4 million was authorized for capital outlays.

Each campus operated a Non-appropriated Fund Instrumentality (NAFI) known as the AFRH Residents' Fund to support a variety of projects and activities designed to enhance the morale, welfare and general well-being of the residents. The campus Residents' Advisory Council set the annual budget and the Chief, Leisure and Wellness expended funds throughout the year. Projects and activities included dances, bingo, games, picnics, and holiday/theme dinners. According to AFRH Directive 8-4 (still in draft format), the Residents' Fund may derive income from any lawful sources other than through appropriated government funds. Sources of income included donations and bequeaths, Army Air Force Exchange Service (AAFES) proceeds, telephone service and vending machine commissions, and fees charged for various activities. In addition, AFRH-W operated a golf course which generated revenue. Funds that exceeded current needs were invested in deposits insured by the Federal government. As of 30 June 2005, funds on deposit were approximately $1.2 million for AFRH-G and $721,000 for AFRH-W. Budgeted expenses for 2005 were approximately $154,000 for AFRH-G and $185,000 for AFRH-W.

In April 2004, the accounting function for the Residents' Funds was transferred to the Navy Morale, Welfare, and Recreation (MWR) accounting office at Millington TN. Millington recorded revenues and expenditures, issued some checks, reconciled deposits, and invested funds.

The Director of each campus collected a monthly fee from each resident. The fee was calculated by taking the sum of all previous year income and deducting the amounts currently paid for Medicare Part B and supplemental health insurance and stipend money earned at the campuses. The calculated sum was divided by 12 to determine the monthly income. The resident fee was 35 percent of monthly income for independent living, 40 percent for assisted living, and 65 percent for long-term health care, subject to the maximum limitation for each campus. Each resident provided required documentation to the Business Center annually to determine the monthly fee. If the necessary documentation was not received by 1 December, the maximum monthly fee was charged in the next year until the documentation was received.

Findings and Actions Required

***(D-01 Finding):** The 30 September 2004 AFRH Trust Fund balance was not accurately portrayed in the FY06 Presidential Budget Submission.

Finding Cause Code: Experience

Observations: The amounts to be included in the AFRH Trust Fund were governed by 24 U.S.C. § 419. The 30 September 2004 Trust Fund balance was $118 million; however, the FY06 Presidential Budget Submission indicated a fund balance of $70 million. BPD stated the correct balance was $81million on the output generated by Office of Management and Budget (OMB) budget system (MAX). After several discussions with BPD and AFRH, the inspectors validated that the Presidential Budget Submission of $70 million was in error based on faulty inputs by AFRH on balances preceding FY04 and prior to the migration to BPD for accounting processing. Accordingly, the correct balance on MAX was $81 million as of 30 September 2004. As a result, subsequent Trust Fund balance calculations were inaccurately recorded.

Through interviews and research, the inspection team determined that the difference between the MAX balance and the statutory Trust Fund balance on 30 September 2004 was attributable to budgetary accounting differences. The Max balance did not capture $37 million in prior approved unexpended spending authority and only showed the amount of the Trust Fund where there was no authority to spend.

Actions Required: CFO correct future MAX budget submissions to reflect an $11 million adjustment and consider a mechanism to explain any differences between the MAX system and the Trust Fund balance IAW 24 U.S.C. § 419.

***(D-02 Finding):** AFRH did not file audited financial statements for FY03 and FY04.

Finding Cause Code: Experience

Observations: AFRH was subject to the annual audit requirement set forth in the Chief Financial Officers' Act of 1990. The last audit for AFRH was for the period ending 30 September 2001, at which time AFRH received a qualified audit opinion from its independent auditing firm. In a memorandum to OMB, dated 4 November 2004, the AFRH CFO stated that the Home's intention was to have an audit conducted on the FY04 financial statements. AFRH requested contract bids and subsequently received quotes from two firms. Due to a misunderstanding of the requirements between the contracted audit firm and AFRH, the audit time frame for FY 2004 was not met. Furthermore, AFRH did not furnish written waivers from OMB for failing to meet the FY03 and FY04 audit requirements.

AFRH had contracted with Brown & Company to conduct an audit for FY05. Brown & Company developed a timeframe that will enable AFRH to file its audited financials in a timely manner. Inspectors reviewed the engagement letter submitted by Brown & Company, dated 14 May 2005, which confirmed that the audit services will meet the audit requirements of the Chief Financial Officers' Act of 1990, the Taxpayer Accountability Act of 2002 and other authorities to include guidance from the OMB, Government Accounting Office (GAO), Federal Accounting Standards Advisory Board (FASAB) and the Department of Treasury. Based on representations contained in this letter, the audit scope appeared adequate. The inspection team also evaluated the audit delivery schedule and confirmed that preliminary audit work for FY05 had commenced.

Actions Required: CFO monitor execution of the upcoming Brown & Company audit for FY05 to ensure compliance with the Chief Financial Officers' Act of 1990 (Title III, § 304a).

***(D-03 Finding):** AFRH did not establish effective oversight of financial transaction processing.

Finding Cause Code: Oversight

Observations:

Accounts Receivable Reconciliation: Prior to March 2005, a monthly reconciliation between the accounts receivable subsidiary records and the general ledger control accounts did not occur. During March 2005, BPD initiated a requirement for AFRH to furnish a copy of their accounts receivable subsidiary records each month. In addition, notification of adjustments such as non-sufficient funds checks between AFRH and BPD was established.

Upon conversion to the new accounting system in April 2004, the balance in the AFRH-W subsidiary records was not recorded in the general ledger accounts receivable balance. In fact, only the current receivables were recorded. BPD stated this occurred because they could not

substantiate the legitimacy of the AFRH records at the time of conversion to the new accounting system. For those accounts subsequently deemed collectible from prior years by AFRH, BPD recorded a one-time adjustment in July 2005 for $157,644.17 by establishing an accounts receivable entry into the general ledger. However, BPD erroneously credited current revenue rather than creating a prior period adjustment, which resulted in recording the revenue twice (once when originally recognized in prior years and again in the June 2005 financial statement). Inspectors discussed this with BPD and the CFO, and they agreed a prior period adjustment was required by generally accepted accounting principles.

Deposit Verification: There was not a mechanism or procedure in place to verify whether funds deposited by AFRH were recorded by BPD. Recently, procedures were implemented to verify receipts for resident fees (March 2005), quarterly fees (March 2005) and lease payments (July 2005). However, AFRH did not verify whether funds for donations, meal sales, guest house fees and coupons were recorded on the AFRH financial statement records maintained by BPD. Inspectors found no instances of noncompliance where a deposit was not recorded. Inspectors did note the BPD Deposit Breakdown for Leases did not accurately reflect the proper funds deposited for a lease payment. Specifically, deposit records from AFRH-W amounting to $134,453.71 were sent to BPD. BPD internal records only reflected a balance of $97,350.00. The $37,103.71 discrepancy was corrected during the inspection.

Revenue Classification: AFRH did not establish procedures to specifically classify revenue. Inspectors noted several instances where there was uncertainty on which general ledger account and reporting category should be used to record revenues on the financial statement. Checks written from estates at AFRH-W were recorded in the Donated Revenue - Financial Resources (general ledger account 560001), but were erroneously classified under Bequests and Donations (reporting category 12), instead of Estates (reporting category 1). In addition, meal sales were erroneously recorded in Other Revenue (general ledger account 590001) under Miscellaneous, instead of Sales and Leases (reporting category 3).

Actions Required: CFO request BPD to reverse the $157,644 from current revenue and record a prior period adjustment IAW the Statement of Federal Financial Accounting Standards No. 7. CFO establish a tracking system between AFRH and BPD to ensure all deposits are received by BPD. In addition, AFRH and BPD personnel should reach a consensus on the correct classification of revenue accounts and train appropriate personnel. These actions will ensure compliance with the Chief Financial Officers' Act of 1990 (Title II, § 205, Chapter 9, § 902a3).

***(D-04 Finding):** AFRH did not complete an annual Statement of Assurance.

Finding Cause Code: Experience

Observations: The CFO stated that AFRH did not complete the Statement of Assurance in the last three years. The annual Statement of Assurance represents the agency head's informed judgment as to the adequacy and effectiveness of management controls within the agency.

Actions Required: CFO prepare and transmit to the OMB an annual report which includes the Statement of Assurance as required by the Chief Financial Officers' Act of 1990 (Title II, § 205, Chapter 9, § 902a6D) and OMB Circular A-123 (V). The statement must take one of the following forms: statement of assurance; qualified statement of assurance, considering the exceptions explicitly noted; or statement of no assurance.

***(D-05 Finding):** AFRH did not establish a long-term Financial Plan.

Finding Cause Code: Oversight

Observations: AFRH was required to submit a financial management status report and a five-year financial management plan to Congress. AFRH prepared a financial plan that included the current year plus one year for operating costs. The capital outlay plan prepared in conjunction with the financial plan contained some long-range information (spanning eight years), but funds were not executed in a timely manner. As of July 2005, the balance in the Trust Fund applicable to the capital outlay was $22.5 million. The AFRH-G expansion project had a funding authority of $6.2 million in 2002, for a total project cost of $23.8 million. The capital project description in the 2001 and 2002 budget stated the construction began in FY02. During the previous triennial inspection, the inspection team noted that only $1 million of this project was expended, and that was on construction design. As of July 2005, this project was still at $1.073 million in expenditures and it remained in the proposal evaluation stage. The lack of a financial plan and execution strategy in this project created the potential for cost overruns.

Actions Required: AFRH submit a five-year financial plan and revise it annually for both the O&M and capital outlay IAW the Chief Financial Officers' Act of 1990 (Title II, § 205, Chapter 9, § 902a5a). The five-year plan should establish milestones for equipment acquisition and other actions necessary to implement a plan consistent with requirements. The five-year plan would enable managers to budget revenues and expenses, and target Trust Fund balances. AFRH required complete and accurate financial information to make fiscally sound decisions.

***(D-06 Finding):** AFRH did not establish an effective accounting mechanism for the Residents' Funds.

Finding Cause Code: Oversight

Observations: Although AFRH transferred accounting functions for the Residents' Fund, a Non-appropriated fund (NAF), to the Navy MWR accounting office at Millington TN, no formal agreement between AFRH and Millington existed. Therefore, it is not clear what duties Millington was required to perform for AFRH. For example, Millington and AFRH Leisure and Wellness personnel used different codes and categories to classify revenues and expenses. As a result, Millington did not load the annual budget into their accounting system and produce

financial reports that enabled AFRH personnel to adequately track their expenses. Furthermore, AFRH did not establish procedures to review financial data, such as subsidiary ledgers.

Action Required: AFRH develop a formal agreement with the Navy MWR accounting office at Millington TN to include duties to be performed. In addition, AFRH should develop procedures for monitoring work performed by Millington to comply with 24 U.S.C. § 415.

***(D-07 Finding):** AFRH lacked adequate oversight of the Government Purchase Card program.

Finding Cause Code: Training

Observations: AFRH cardholders did not keep a purchase log to aid in the reconciliation process. In a recent surveillance by BPD the Agency Program Coordinator (APC) failed to document the missing purchase logs. Even though cardholders maintained a copy of the monthly statement generated by CitiBank, the log was necessary to show purchase detail at the time of purchase and provide a running balance to prevent overspending on the credit card. Additionally, cardholders were allowed to purchase without accomplishing the required on-line cardholder training course documented by training certificates.

Actions Required: AFRH is required to comply with Treasury Directive 76-04 Government Purchase Card Program and BPD Government Purchase Card Procedures. Section 18 of the BPD guide identifies the actions required for reconciling monthly billing statements. AFRH clearly communicate and standardize Office Program Coordinator duties between the campuses. Office Program Coordinators provide cardholder training, ensure purchase logs are completed and conduct surveillance IAW applicable directives by both AFRH and BPD. In addition, AFRH establish local guidance to provide thresholds for agency-specific purchases due to the unique nature of the campus.

AFRH – GULFPORT

Residents' Fund: At AFRH-G, the Director of Leisure and Wellness received donations and made deposits, in addition to authorizing expenditures and maintaining the fund checkbook. Although the inspection team did not identify any discrepancies, adequate separation of duties to safeguard funds was lacking.

Government Purchase Card: At AFRH-G, it was not clear whether an Office Program Coordinator was assigned. Approving officials and cardholders were unaware of the requirements to maintain training certificates, purchase logs and supporting documentation. With the exception of Campus Operations, no surveillance was performed by the Office Program Coordinator and/or the approving officials.

Area of Strength

The Campus Operations approving official and cardholder maintained excellent documentation for charge card purchases. They effectively maintained cardholder books and monthly purchase logs. In addition, they maintained training certificates and their cross reference to purchase documentation was excellent.

Finding and Actions Required

***(D-08 Finding):** AFRH-G lacked adequate oversight of the Government Purchase Card program.

Finding Cause Code: Training

Observations: The Office Program Coordinator neither reviewed approving official and cardholder files nor maintained training certificates. Two of three cardholders interviewed neither maintained purchase logs nor provided training documentation.

Actions Required: AFRH-G approving officials and cardholders comply with Treasury Directive 76-04 Government Purchase Card Program and BPD Government Purchase Card procedures. AFRH-G implement procedures to ensure an adequate separation of duties for Residents' Fund transactions. AFRH-G establish a standardized method for maintaining approving official and cardholder files to ensure proper documentation is included. Maintain cardholder purchase logs and conduct surveillance IAW applicable AFRH and BPD directives.

Recommendation

(DR-01 Recommendation): AFRH-G implement procedures to ensure an adequate separation of duties for Residents' Fund transactions.

AFRH – WASHINGTON

Residents' Fund: The AFRH-W golf course was operated through a contract (with an annual cost of $106,000) managed by the Director of Leisure and Wellness. At the time of the inspection, FY05 golf course revenues were approximately $150,000, raised through sales of associate memberships and leasing of golf carts. While the contract to manage the golf course was paid with NAF funds, the contract to maintain the golf course grounds was paid with appropriated funds ($1.13 million for five years). Typically, a golf course is classified as a Category C (Revenue-Generating Activities) Moral Welfare and Recreation (MWR) facility, and therefore authorized only limited appropriated fund support. However, because residents were permitted to golf for free, the CFO designated the golf course as a Category B (Community Support Activity) MWR facility whose ability to generate income was limited and required substantial appropriated support. Paying golf course grounds maintenance with appropriated

funds appeared to violate the requirement that NAF funds not be derived from appropriated funds.

Government Purchase Card: At the AFRH-W campus, approving officials and cardholders maintained files with monthly statements and copies of receipts. At the time of the inspection, all were in the process of completing government purchase card training by the 29 July 2005 BPD suspense. The Office Program Coordinator monitored cardholder transactions and spending levels, but did not perform routine surveillance of approving official or cardholder files.

Finding and Actions Required

***(D-09 Finding):** AFRH-W lacked adequate oversight of the Government Purchase Card program.

Finding Cause Code: Oversight

Observations: The Office Program Coordinator neither reviewed approving official and cardholder files nor maintained training certificates. Two of three cardholders interviewed neither maintained purchase logs nor provided training documentation.

Actions Required: AFRH-W approving officials and cardholders comply with Treasury Directive 76-04 Government Purchase Card Program and BPD Government Purchase Card procedures. Section 18 of the BPD guide identified the actions required for reconciling monthly billing statements. AFRH-W establish a standardized method for maintaining approving official and cardholder files to ensure proper documentation is included. Maintain cardholder purchase logs and conduct surveillance IAW applicable AFRH and BPD directives.

Recommendation

(DR-02 Recommendation): AFRH obtain a legal review on the decision to classify the AFRH-W golf course as a Category B MWR facility and the existing policy to pay for golf course grounds maintenance with appropriated funds.

TAB E – RECORDS MANAGEMENT

OVERALL ASSESSMENT

The AFRH records management assessment addressed the Records Management, Freedom of Information Act (FOIA) and Privacy Act (PA) programs to ensure compliance with 5 U.S.C. § 552, 44 U.S.C., Chapters 29, 31, 33 and 35, DOD 5400.7-R and 5400.11-R, DOD Directive 5015.2 and DOD Administrative Instruction (AI) No. 15. Overall, the Records Management programs at the Agency and both campuses were not managed in an effective manner. In addition, the FOIA programs at both campuses and the PA program at AFRH-G were deficient and required immediate attention.

AGENCY

A Records Manager (RM) was recently appointed at the Agency level; however, this individual lacked both experience and training. The AFRH-W RM provided direction and guidance in this area for both the Agency and AFRH-W. Moreover, the incumbent AFRH-W RM retired August 2005 and, at the time of the inspection, a replacement was yet to be named. Information flow between offices was lacking as some offices used locally produced file logs while others did not. There was no off-site storage facility identified to safeguard records and data in the event of an emergency.

The Agency PA program was managed in an adequate manner. PA statements were used on all documents and records. Records were kept in locked cabinets and drawers which provided additional protection and helped safeguard sensitive information. The AFRH-W PA Manager provided most of the oversight and direction for handling PA data; the manager was considered the "resident expert." However, PA training required attention.

The Agency FOIA Manager was yet to be trained. The AFRH-W FOIA Manager staffed all requests for information for both the Agency and the campus. Additionally, the manager provided direction and guidance to the AFRH-G FOIA Manager. Finally, the MOA between AFRH and the 11th Wing Staff Judge Advocate, Bolling AFB for FOIA legal review support to determine release or denial of information had expired.

Findings and Actions Required

***(E-01 Finding):** The Agency Records Management program did not meet minimum DOD requirements.

Finding Cause Codes: Guidance

Observations: Several years had elapsed since the consolidation of the Gulfport campus (formerly known as the United States Naval Home) and the Washington campus (formerly

known as the United States Soldiers' and Airmen's Home) into the Armed Forces Retirement Home (AFRH). In this time, the Agency did not develop standardized Records Management policy and guidance for both campuses to follow. As a result, the Gulfport campus used Navy policy while the Washington campus used Army policy. In the spring of 2005, the Agency worked with the National Archives Records Administration (NARA) to start developing Agency-level rules and procedures for managing records. The Agency obtained an NARA-approved SF 115, Request for Records Disposition Authority, for Records Management personnel to use as a roadmap for developing a viable filing system. In addition, the Agency did not establish procedures for identifying and maintaining inactive files. Finally, in case of an emergency, the Agency did not identify an off-site location for storing vital records to guard and protect against natural or intentional disasters.

Actions Required: Continued attention is needed to ensure both AFRH-W and AFRH-G RMs and Record Custodians (RC) receive standardized Agency-level policy and guidance and are properly trained IAW DOD AI 15. In addition, develop a records filing system using the NARA-approved Records Disposition Authority and identify an off-site location to store vital records in case of an emergency.

AFRH – GULFPORT

At the time of the inspection, the appointed RM had not received training for administering a records filing system. Overall, the Records Management program did not meet DOD requirements. The inspection team noted the existence of approximately 40 boxes of documents (engineering, financial, personnel actions and maintenance/service contracts) in a storage room dating back to 1996. These documents were awaiting disposition for destruction or transfer to the NARA for long-term storage. According to staff personnel, cuts in administrative support made it difficult to delegate preparation of appropriate forms to destroy outdated records and files. In addition, the PA and FOIA programs did not meet DOD or public law requirements.

Findings and Actions Required

***(E-02 Finding):** The AFRH-G Records Management program did not meet minimum DOD requirements.

Finding Cause Codes: Guidance

Observations: AFRH-G continued to use the Navy filing codes system even though the Agency had an NARA-approved SF 115. The RM and RCs received no Records Management training and lacked procedures to maintain records. Neither the Agency nor the RM established procedures for properly identifying and maintaining inactive files. Finally, in case of an emergency, an off-site location was not identified for storing vital records to guard and protect against natural or intentional disasters.

Actions Required: Work together with the Agency and AFRH-W to provide standardized guidance and ensure proper RC training is accomplished. In addition, develop a filing system using the NARA-approved Records Disposition Authority and identify an off-site location to store vital records in case of an emergency.

***(E-03 Finding):** The AFRH-G Privacy Act program did not meet minimum DOD requirements.

Finding Cause Codes: Training

Observations: Although a PA Manager was appointed in writing, initial or refresher training was lacking. With only one exception, reviewed admission folders contained initial admission denials without PA coversheets and statements. In addition, discharge records were stored together with denial records for admissions. A review of denial records revealed that only three letters of denial for admission were signed. There was no procedure to ensure signed copies were placed in applicant files. Furthermore, numerous folders containing insurance benefits and resident leave information were filed without PA coversheets and statements.

Actions Required: Properly train all personnel handling PA information to ensure documents are protected and safeguarded under the Privacy Act of 1974 IAW DOD AI 15. Correct deficiencies noted in the above observations.

***(E-04 Finding):** The AFRH-G Freedom of Information Act program did not meet minimum public law requirements.

Finding Cause Codes: Training

Observations: The AFRH-G FOIA Manager did not receive initial or refresher training prior to processing FOIA requests. The manager solicited assistance from the AFRH-W FOIA manager who ensured a legal review was accomplished prior to responding to requests for information. There was no formal process in place for maintaining and tracking cases; immediate action was taken to correct this discrepancy. The lack of a file maintenance and disposition plan contributed to FOIA request denials not being kept on hand (for disposal). AFRH-G assigned only one person to handle FOIA requests. Finally, the Fiscal Year End Report submission was not being prepared and sent to the Directorate of Freedom of Information and Security Review office. According to the AFRH-G FOIA manager, data for the report was sent to the AFRH-W FOIA manager for consolidation. However, the AFRH-W FOIA manager was unaware of this consolidation and stated this had never been accomplished before.

Actions Required: Properly train primary and alternate FOIA Managers to ensure program management IAW 5 U.S.C. § 552. Maintain and dispose of FOIA records IAW the NARA-approved General Records Schedule. Furthermore, maintain denied FOIA requests for a period of six years to meet the statute of limitations requirements. Working with the Agency, make

available all non-exempt records in the Agency's reading room (both in paper and electronic form) to facilitate public access. Finally, forward the campus Fiscal Year End Report input to the Agency FOIA Manager for consolidation.

AFRH – WASHINGTON

At the time of the inspection, the appointed RM had not received training for administering a records filing system. Overall, the records management program did not meet DOD requirements. According to staff personnel, significant cuts in administrative support created work load challenges. Although the appointed PA Manager had never received training, the manager maintained the PA program in an adequate manner. Pertinent data was kept on file with PA statements and was stored in a locked file cabinet which provided additional protection. Records were available at all times and provided upon request. Identification checks were conducted before records were released to requestors. In addition, the FOIA program did not meet DOD or public law requirements.

Findings and Actions Required

***(E-05 Finding):** The AFRH-W Records Management program did not meet minimum DOD requirements.

Finding Cause Codes: Guidance

Observations: AFRH-W continued to use the Army filing codes system even though the Agency had an approved SF 115. The RM and RC received no records management training and lacked procedures to maintain records. Neither the Agency nor the RM established procedures for properly identifying and maintaining inactive files. Finally, in case of an emergency, an off-site location was not identified for storing vital records to guard and protect against natural or intentional disasters.

Actions Required: Work together with the Agency and AFRH-G to provide standardized guidance and ensure proper RC training is accomplished. In addition, develop a filing system using the NARA-approved Records Disposition Authority and identify an off-site location to store vital records in case of an emergency.

***(E-06 Finding):** The AFRH-W FOIA program did not meet minimum public law requirements.

Finding Cause Codes: Training

Observations: The AFRH-W FOIA Manager did not receive initial or refresher training prior to processing FOIA requests. The AFRH-W FOIA Manager handled all requests for both the campus and the Agency. No formal process was in place for maintaining and tracking cases;

immediate action was taken to correct this discrepancy. The lack of a file maintenance and disposition plan contributed to FOIA request denials not being kept on hand (for disposal). AFRH-W assigned only one person to handle FOIA requests. In addition, the Fiscal Year End Report submission was not being prepared and sent to the Directorate of Freedom of Information and Security Review office. Finally, the Memorandum of Agreement (MOA) for legal review determination of releases or denials of information had expired with the Bolling Air Force Base legal office.

Actions Required: Properly train primary and alternate FOIA managers to ensure program management IAW 5 U.S.C. § 552. Maintain and dispose of FOIA records IAW the NARA-approved General Records Schedule. Furthermore, maintain denied FOIA requests for a period of six years to meet the statute of limitations requirements. Working with the Agency, make available all non-exempt records in the Agency's reading room (both in paper and electronic form) to facilitate public access. Finally, work with the AFRH-G FOIA Manager to consolidate, prepare and forward the Fiscal Year End Report to the Directorate for Freedom of Information and Security Review office by November 30 of each year. Renew MOA with 11th Wing Staff Judge Advocate or negotiate with another DOD agency to provide legal support for FOIA.

TAB F – INFORMATION TECHNOLOGY

OVERALL ASSESSMENT

Recently, AFRH instituted a number of significant information technology (IT) changes across both campuses and the Agency. At the time of the inspection, all applications, file storage and E-mail services were being migrated to a web-based enterprise architecture. The purpose of the migration was to enhance accessibility to information and services. However, the emphasis on transitioning to a web-based architecture came at the expense of the static infrastructure of both campuses. Clients at both campuses used operating systems that had ineffective or no security safeguards. Information systems management oversight was lacking. Furthermore, Software License Management programs did not exist at either campus. Overall, AFRH did not comply with Federal Information Systems Management Act (FISMA), Office of Management and Budget (OMB) Circular A-130 and Executive Order 13103 information technology requirements.

The campus IT staffs were reduced from three positions to one at AFRH-G and from six positions to two at AFRH-W. AFRH no longer possessed the number of IT personnel required to operate the network as it is currently configured. As a result, segments of the network functioned at speeds that were well below the industry norm. The transition to a web-based enterprise architecture, when completed, will not address the issues identified in this report.

AGENCY

Agency IT requirements were managed by AFRH-W IT personnel.

Findings and Actions Required

None noted.

Recommendation

(FR-01 Recommendation): Based on the significant IT deficiencies regarding compliance with FISMA and other federal government requirements, the inspection team recommends that AFRH leadership work with OSD to review the IT structure and configuration requirements and determine whether adopting DOD IT standards is appropriate and necessary. Furthermore, the team recommends establishing support agreements with local military facilities to help AFRH manage IT infrastructure and network requirements at both AFRH-G and AFRH-W.

AFRH – GULFPORT

The AFRH-G IT staff consisted of one contractor who was responsible for the operation of approximately 75 clients. The clients were configured to operate in a workgroup, as opposed to

a domain, and used a variety of operating system platforms to include Windows 95, Windows 98, Windows Me, Windows NT 4, Windows 2000 and Windows XP. This configuration necessitated establishing policies (security, password, access and auditing) locally on each individual client. However, no policies were established and all users had administrative rights. Additionally, all inspected clients maintained the original default operating system configuration settings. These settings allowed users to set passwords of zero characters; users needed only to hit [Enter] for computer access.

Individuals also shared user names and passwords to access individual workstations. Furthermore, clients were configured to allow system access across the network to everyone. Clients were not configured to perform any type of auditing; therefore, no record of access (system or object) was created.

AFRH had a verbal policy that users were to use the file storage provided by the Oracle Collaboration Suite for saving files. However, numerous operating systems at individual workstations were found to contain files containing private information relating to patient information, treatments and/or medications.

AFRH-G was not able to provide a graphic representation of the network infrastructure. Patch panels, switches, hubs and Cat 5 cables were not labeled. As a result, termination points were not readily identified. The lack of network diagrams and proper labeling prevented effective fault isolation and troubleshooting.

The configuration of the network as a workgroup versus a domain prevented the system administrator from making use of the tools inherent in later versions of Windows operating systems. The contractor was required to physically touch each individual system to configure adequate security, auditing and proper patch management. This was time-consuming and inefficient. A domain infrastructure allows the establishment of group policies, auditing and automated deployment of software patches.

Internet access was provided by a commercial Internet Service Provider (ISP) which also provided the firewall. AFRH-G did not maintain an internal firewall and lacked control to block or allow access.

Additionally, software license management was non-existent. Licensed software was not inventoried or secured. Moreover, workstation audits were not conducted to determine installations. Users were able to install personally acquired software to include games, shareware, freeware and spyware. The inability of AFRH-G to demonstrate proper licensed ownership of installed software opened the Agency to potential financial liability.

Findings and Actions Required

***(F-01 Finding):** AFRH-G did not establish a Software License Management program to ensure compliance with Executive Order 13103 requirements.

Finding Cause Code: Oversight

Observations: Commercial software and licenses were found distributed haphazardly throughout the campus. There was no indication that AFRH-G had ever conducted an inventory of purchased software. User required training documentation was lacking. Multiple instances of freeware and shareware were found installed on operating systems. Two systems were found to have remote control software, unbeknownst to the system administrator.

Actions Required: Establish Software License Management program policy and guidance to ensure compliance with Executive Order 13103 requirements.

***(F-02 Finding):** AFRH-G did not establish an information systems management oversight function to ensure compliance with FISMA and OMB Circular A-130 requirements.

Finding Cause Code: Oversight

Observations: Although AFRH-G was aware of the existence of FISMA, they were not aware of their Agency requirements. AFRH-G did not establish standards; therefore, they could not test, review and/or report on information systems management oversight.

Actions Required: Establish an Information Systems Management oversight function to ensure compliance with FISMA and OMB Circular A-130 requirements.

AFRH – WASHINGTON

The AFRH-W IT staff consisted of one civil service employee and one contractor responsible for the operation of approximately 200 clients, one Novell server and one NT file server for both AFRH-W and the Agency. The clients used a variety of operating system platforms to include Windows 98, Windows Me, Windows 2000 and Windows XP.

As at AFRH-G, the clients were configured to operate in a workgroup, as opposed to a domain. The existing configuration necessitated establishing policies (security, password, access and auditing) locally on each individual client. Additionally, all inspected clients maintained the original default operating system configuration settings. These settings allowed users to set passwords of zero characters; users needed only to hit [Enter] for computer access. Although the majority of clients operated with Novell Client software to restrict access to the Novell server, this was not always the case.

Individuals also shared user names and passwords to access individual workstations. Inspected clients were configured to allow system access across the network to everyone. Clients were not configured to perform any type of auditing; therefore, no record of access (system or object) was created.

AFRH-W was not able to provide a graphic representation of the network infrastructure. Patch panels, switches, hubs, fiber optic and Cat 5 cables were not labeled. The fiber optic cable termination points could not be identified. The lack of network diagrams and proper labeling prevented effective fault isolation and troubleshooting.

Many of the hubs were 10BaseT operating at a maximum rate of 10 Mbps. The fiber-optic and Cat 5 backbone were 100BaseT and 100 Mbps capable. The Digital Signal Level 3 (DS3), also known as T3, was capable of speeds of up to 43 Mbps. Therefore, the potential for network bottlenecks existed. Critical network segments were housed in a room that lacked climate control. As a result, these segments were at risk due to excessive room ambient temperature.

The configuration of the network as a workgroup versus a domain required the IT staff to physically touch each individual system to configure adequate security, auditing and proper patch management. This was time-consuming and inefficient. A domain infrastructure allows the establishment of group policies, auditing and automated deployment of software patches.

Internet access was provided by a commercial ISP. AFRH-W maintained an internal firewall and it was properly configured to prevent external access. However, this firewall was scheduled to be removed as part of the network upgrade.

Additionally, software license management was non-existent. Licensed software was not inventoried or secured. Moreover, workstation audit capability did not exist to determine installations. Users had installed personally acquired software to include games, shareware, freeware and spyware. The inability of AFRH-W to demonstrate proper licensed ownership of installed software opened the Agency to potential financial liability.

Findings and Actions Required

***(F-03 Finding):** AFRH-W did not establish a Software License Management program to ensure compliance with Executive Order 13103 requirements.

Finding Cause Code: Oversight

Observations: AFRH-W lacked established procedures to ensure that the Agency did not acquire, reproduce, distribute and/or transmit computer software in violation of applicable copyright laws. There was no indication that AFRH-W ever conducted an inventory of purchased software. AFRH-W could not produce licenses for various pieces of software. User

required training documentation was lacking. Multiple instances of freeware and shareware were found installed on operating systems.

Actions Required: Establish Software License Management program policy and guidance to ensure compliance with Executive Order 13103 requirements.

***(F-04 Finding):** AFRH-W did not establish an information systems management oversight function to ensure compliance with FISMA and OMB Circular A-130 requirements.

Finding Cause Code: Oversight

Observations: AFRH-W was not aware of Agency requirements under FISMA. AFRH-W did not establish standards; therefore, they could not test, review and/or report on information systems management oversight.

Actions Required: Establish an Information Systems Management oversight function to ensure compliance with FISMA and OMB Circular A-130 requirements.

TAB G – CONTRACTING

OVERALL ASSESSMENT

AFRH partnered with the Bureau of Public Debt (BPD) to provide contracting services for supplies and services. Overall, BPD provided the Agency adequate service IAW the Federal Acquisition Regulation (FAR) and Department of Treasury Acquisition Regulation (DTAR). However, several areas noted during this inspection required additional AFRH and BPD attention and effort to resolve. The areas are listed below.

1. An overall strategic plan for the acquisition of supplies and services did not exist.
2. Acquisition plans for individual contracts did not exist.
3. Adequate quality assurance surveillance plans (QASP) and assurance measures were not in place.
4. Annual contractor performance evaluations were not accomplished.
5. Contract clause requirements for government furnished property, material, and facilities contracts were not met.
6. Consistent policy and guidance for Contracting Officer Technical Representatives (COTR) were lacking.
7. Contracts were not funded appropriately.

AGENCY

In 2004, AFRH outsourced their purchasing responsibilities to the BPD's Administrative Resource Center (ARC) in Parkersburg WV. BPD provided procurement services IAW the Memorandum of Understanding (MOU) between the Treasury Franchise Fund ARC and AFRH. Services included simplified acquisitions, formal contracts (over $100,000) and contract administration. Contracting service was conducted IAW the FAR and the DTAR. BPD is awarding and administering new contracts along with administering existing contracts from AFRH. The FY 05 cost for performing procurement services was $337,737 and $185,955 for simplified acquisition services for a total of $523,692. A new cost schedule will be prepared and approved by ARC and AFRH prior to the beginning of each annual service period.

Overall, BPD maintained AFRH contract files in an effective and consistent manner. However, some FAR and DTAR contract discrepancies were noted. BPD was also effectively managing existing contracts transferred from AFRH despite some of the files not containing all required file documentation. BPD contracting personnel interacted with the COTRs at both AFRH campuses by phone, E-mail and visits to resolve issues. COTR interviews indicated that they received efficient BPD support for the procurement of services. However, several COTRs stated concerns regarding the timeliness of the support they received for construction and medical services.

Additionally, several acquisition planning concerns were noted that required AFRH and BPD attention. AFRH and BPD did not establish an overall strategic plan resulting in haphazard procurement contracts. Moreover, AFRH and BPD did not establish an acquisition plan for individual contracts. As a result, efforts of all personnel responsible for significant aspects of the acquisition process were not integrated.

Three of six AFRH services contracts reviewed did not use required Performance Based Services Acquisitions (PBSA). While the AFRH-W food services contract was a PBSA contract, the AFRH-G food services contract was not. However, the statement of work (SOW) and/or performance work statement (PWS) for both campuses contained the same detailed requirements for food services. The only difference was in the AFRH-W PWS performance summary; it included incentives and disincentives. Attention was required to ensure that PBSA was used for service contracts whenever practicable.

Twenty-four COTRs [14 of 15 at AFRH-G and 10 of 22 at AFRH-W] and their contract files were interviewed and assessed to determine compliance with DTAR 1001.670 and BPD COTR Resource Guide requirements. Overall, COTRs maintained contract files and required documentation in an efficient and organized manner. However, several COTR program DTAR discrepancies were noted during interviews. When COTRs were asked if they had the required technical expertise and experience to perform delegated contract administration duties, including evaluating contract performance, 20 of 24 stated that they did and four stated that they did not. Also, six stated that they did not jointly review their responsibilities with the contracting officer. In addition, interviews revealed that COTRs did not have a clear understanding of the DTAR requirement for eight hours of maintenance training each year. The DTAR provided examples of maintenance training to include acquisition, technical, job-specific and/or project management courses. Fourteen of the twenty-one COTRs who received annual maintenance training stated that it was follow-on COTR training provided by BPD. While detailed, the Bureau's follow-on training did not focus on technical and/or job-specific requirements. Attention was required to ensure COTRs had the technical expertise and knowledge to evaluate contract performance and deliverables.

Findings were based upon noted trends across both campuses. Deficiencies require Agency-level attention; therefore, all findings are directed to the Agency.

Findings and Actions Required

***(G-01 Finding):** AFRH, working with BPD, did not establish an overall strategic plan to ensure use of a systematic and disciplined approach to achieve effective AFRH acquisition.

Finding Cause Code: Oversight

Observations: AFRH and BPD did not have a consistent plan for current and future acquisitions. For example, BPD accomplished the majority of AFRH purchasing; however, contracts existed

with other governmental and non-governmental agencies. Also, contracts were awarded throughout the year with no consistent period of performance and file documentation to account for such actions was lacking. Additionally, for contracts with a one year period of performance that crossed fiscal years, file documentation to indicate whether funding was provided by future appropriation (FAR 32.703-2) or the service was severable (FAR 32.703-3(b)) was lacking. Moreover, no consideration was given to combining campus efforts. The food services contract for both campuses was managed by the same contractor; however, campuses used separate contracts. Finally, there was no evidence that either AFRH or BPD maintained a complete list of contracted efforts and leases for AFRH properties including government owned quarters.

Actions Required: AFRH and BPD establish a long-range strategic plan for AFRH acquisitions that addresses both near and long-term requirements IAW FAR Subpart 7.1, *Acquisition Plans.*

***(G-02 Finding):** AFRH, working with BPD, did not establish an acquisition plan for individual contracts.

Finding Cause Code: Experience

Observations: Review of AFRH contract files revealed a lack of acquisition planning documentation as required by FAR and DTAR Part 7. There was no evidence that BPD teamed with AFRH to provide the most effective, economical, and timely acquisition that met the Home's needs. Moreover, BPD did not include an acquisition plan in efforts that used FAR Part 12 for commercial acquisitions.

Actions Required: AFRH and BPD ensure that acquisition plans are included in acquisition contracts. Plans need to integrate the efforts of all personnel responsible for significant aspects of the acquisition at both AFRH and BPD to ensure that requirements meet the customer's needs and expectations. According to FAR 7.102(a) and (b), agencies shall perform acquisition planning and this planning shall integrate the efforts of all personnel responsible for significant aspects of the acquisition. FAR 7.103(e) states agency heads shall write plans either on a system basis, an individual contract basis, or an individual order basis, depending upon the acquisition. Furthermore, FAR 7.105 states that plans must address all the technical, business, management and other significant considerations that control the acquisition. It also emphasizes that acquisition plans for service contracts or orders must describe the strategies for implementing performance-based contracting methods or must provide rationale for not using those methods. DTAR 1007.103(d) states a written plan is required for each commercial source acquisition exceeding the simplified acquisition threshold.

***(G-03 Finding)**: AFRH, working with BPD, did not establish and use quality assurance surveillance plans (QASP) for service contracts. Also, they were not performing contract quality assurance actions.

Finding Cause Code: Oversight

Observations: AFRH and BPD did not establish and use QASPs for service contracts. QASPs were required to ensure AFRH received the quality of services called for under the contract and paid only for the acceptable level of services received. A review of four AFRH-G and four AFRH-W contract files revealed no QASP or quality evaluation documentation. For formal contracts, the BPD's COTR delegation letter required two quality assurance actions. The first action was to determine the level of quality assurance needed to ensure that services were received IAW the contract. The second action was to write and execute an appropriate surveillance plan. Of the 24 COTRs interviewed, only one used a QASP and another used a surveillance schedule. The others stated that they depended on one or more of the following: experience, resident and staff complaints or comments, contractor invoices, whether or not the contractor showed up for work, and spot checks. With one exception, no documentation existed to show that COTRs established and used QASPs.

Actions Required: AFRH and BPD ensure that QASPs and quality evaluations of contractors are accomplished IAW FAR 37.602-2 and 46.104. QASPs and quality evaluations define what AFRH must do to ensure that contractors perform IAW SOW and PWS performance standards.

***(G-04 Finding):** AFRH, working with BPD, did not accomplish annual contractor performance evaluations using the Contractor Performance System (CPS).

Finding Cause Code: Experience

Observations: AFRH and BPD did not comply with FAR and DTAR annual contractor performance evaluation requirements. COTR interviews and review of contracts revealed that the evaluations were not accomplished before or after AFRH outsourced purchasing responsibilities to BPD. BPD recognized this deficiency and planned to implement evaluations in the fall 2005 time frame.

Actions Required: AFRH and BPD ensure that annual evaluations of contractor performances are accomplished on formal contracts using the Department of Treasury CPS. FAR 42.1502(a) requires agencies to prepare an evaluation of contractor performance for each contract in excess of $100,000 at the time the work under contract is completed. In addition, interim evaluations should be prepared if the period of performance exceeds one year including options. FAR 42.1501 states that "Past performance information is relevant information, for future source selection purposes, regarding a contractor's actions under previously awarded contracts. It includes, for example, the contractor's record of conforming to contract requirements and to standards of good workmanship; the contractor's record of forecasting and controlling costs; the contractor's adherence to contract schedules, including the administrative aspects of performance; the contractor's history of reasonable and cooperative behavior and commitment to customer satisfaction; and generally, the contractor's business-like concern for the interest of the customer."

***(G-05 Finding):** AFRH, working with BPD, did not use the appropriate clauses on contracts that contained requirements for government furnished property (GFP), government furnished material (GFM) and/or government furnished facilities in the SOW and PWS.

Finding Cause Code: Experience

Observations: AFRH and BPD did not use the appropriate FAR Part 45 clauses on contracts that contained government furnished property, material and facilities. As a result, AFRH did not accomplish a review of the contractors' property control systems. Food services and transportation contracts included GFP and government furnished facilities to perform services. However, there were no requirements in the contract for the contractor to account for GFP, report any loss or damage or maintain property records. As the contract administrator, BPD was responsible for the review and approval of contractor property control systems. According to the AFRH Agency Notice, Subject: Contracting Officer Representatives (COR), one of the COTR's primary responsibilities was to monitor contract performance, ensuring AFRH paid only for the goods and services authorized and delivered under the contract. Note: AFRH used the term "COR" in lieu of COTR.

Actions Required: AFRH and BPD ensure that the SOW and PWS containing GFP, GFM and/or government furnished facilities include the appropriate FAR Part 45 clause so the contractor is required to maintain a property control system that can be reviewed and approved by BPD.

***(G-06 Finding):** AFRH, working with BPD, did not ensure consistent COTR policy and guidance.

Finding Cause Code: Guidance

Observations: The inspection team identified four documents that contained COTR responsibilities. They included the DTAR, BPD COTR Resource Guide, BPD COTR Delegation Letter, and draft AFRH Agency Notice, Subject: Contracting Officer Representatives. A review of these documents revealed several inconsistencies between them. One inconsistency was in the area of training. The DTAR required that COTRs receive at least 24 hours of a basic acquisition course and eight hours of maintenance training each year. However, the draft AFRH Agency Notice required 24 hours of COR training, four hours of procurement ethics training and an eight-hour refresher course after three years. Another inconsistency was in the area of COTR/COR responsibilities. The Bureau's COTR Resource Guide and Delegation Letter, and the draft AFRH Agency Notice, each contained a different list of responsibilities.

Actions Required: AFRH and BPD ensure COTR policy and guidance are consistent between the organizations and complies with DTAR 1001.670 requirements. Update and publish the AFRH Agency Notice, Subject: Contracting Officer Representatives; ensure it conforms to the Home's Business Model and 24 U.S.C. § 415.

***(G-07 Finding):** AFRH did not properly fund firm fixed price contracts.

Finding Cause Code: Oversight

Observations: AFRH routinely used firm fixed priced contracts that required fully funded efforts. However, due to internal funding limits, AFRH funded these contracts on an "incremental" basis which required BPD to issue numerous modifications. Incremental funding is only authorized for cost reimbursement and the material portion of a Time and Materials (T&M) contract. In May 2005, the Department of Treasury, Office of the Procurement Executive, conducted a compliance review at the ARC, BPD and provided a recommendation that BPD should "Ensure that the use of incremental funding is limited to cost reimbursement contracts and the material portion of a T&M contract."

Actions Required: AFRH ensure that firm fixed price contracts are funded appropriately IAW FAR 32.703-1 and not "incrementally."

Recommendations

(GR-01 Recommendation): AFRH provide resources to ensure QASPs are established and used. Examples can be found at the Defense Acquisition University, Acquisition Community Connection at https://acc.dau.mil.

(GR-02 Recommendation): AFRH request that BPD add Department of Treasury Contractor Performance System and FAR 42.1501 requirements training to the COTR training provided by BPD contracting office.

AFRH – GULFPORT

AFRH-G, working with BPD, maintained various contracts to provide support and other types of service to the campus. These contracts were managed by two full-time and 13 additional duty COTRs. Overall, COTRs performed their duties in a professional manner. They maintained contract files and required documentation in an efficient and organized manner. However, several areas noted during this inspection required additional AFRH and BPD attention and effort to resolve.

Findings and Actions Required

Agency findings are applicable to AFRH-G.

AFRH – WASHINGTON

AFRH-W, working with BPD, maintained various contracts to provide support and other types of service to the campus. These contracts are managed by two full-time and 20 additional duty COTRs. Overall, COTRs performed their duties in a professional manner. They maintained contract files and required documentation in an efficient and organized manner. However, several areas noted during this inspection required additional AFRH and BPD attention and effort to resolve.

Findings and Actions Required

Agency findings are applicable to AFRH-W.

TAB H – CIVIL ENGINEERING

OVERALL ASSESSMENT

The AFRH civil engineering assessment addressed facility planning, programming, management and operations. The Agency Chief Architect and Campus Operations Directors at each campus were responsible for civil engineering operations and support. Agency and campus civil engineering personnel were dedicated, knowledgeable and enthusiastic. No public laws, federal regulations or DOD guidance governed Campus Operations requirements. However, policy and guidance for individual programs did exist: Presidential Executive Order 13123 for energy conservation, 36 CFR 60.9 for historic preservation and the International Building Code (IBC) for construction.

Each Campus Operations staff operated in a unique manner. Recently, AFRH-W lost its A-76 competition and operated with a contract workforce. AFRH-G won its A-76 competition and operated with an in-house workforce. Additionally, AFRH-W was significantly larger, both in land and facilities, than AFRH-G. Although both Campus Operations staffs were responsible for identical functions, they did not have common configurations, software or directives. Moreover, at AFRH-W, strategies for maintaining historic buildings and an Energy Conservation program were lacking. Additionally, the AFRH-W Master Plan did not account for all campus facilities and assets.

AGENCY

The Chief Architect provided technical support to each of the Campus Operations staffs and managed the Agency's capital improvements program in an effective manner. Moreover, strong lines of communication were evident between the Chief Architect and the Campus Operations staffs. However, there was no evidence of specific policy and guidance that established roles and responsibilities between the Agency leadership, Chief Architect and Campus Operations staffs. Procedural guidelines were not established for project approval thresholds, acquisition strategies or technical review requirements. Additionally, common format standards for statements of works (SOW), requests for proposals (RFP), contract specifications and cost estimates were lacking.

Indefinite Delivery Indefinite Quantity (IDIQ) contracts were established to provide traditional Architect and Engineering (AE) services and land use planning. Quality assurance of these contracts was accomplished by one IDIQ contractor who technically reviewed the work of others. However, this was not done as a standard operating procedure, but on a discretionary basis. Often, the Chief Architect reviewed engineering designs that were out of his discipline.

Master plans were developed for both campuses and Campus Operations staffs were actively involved. The AFRH-G Master Plan was detailed and comprehensive; it covered all campus property and facilities including new facility additions, road realignments and primary facility

expansion. The master plan was supported by phasing plans and associated cost estimates. The AFRH-W Master Plan was divided into two separate actions, a general land use development plan and a master plan for Scott Hall. The land use development plan was well developed. Highlights included a Phase I environmental impact study, historical properties inventory, future land use plan and documented coordination activity with governing regulatory agencies. The AFRH-W Master Plan would benefit from taking into account all campus facilities and assets. The lack of experienced planners who could provide quality assurance and supporting economic analysis for proposed capital improvement projects were shortfalls in the master plans of both campuses.

Recently, the Agency selected the Bureau of Public Debt (BPD) to provide contracting support for both services and construction. The relationship between the BPD, Agency and each campus was not well defined. The campuses conducted business with BPD without clear directives or procedural guidance. Interview with staff and documentation review at the Agency and campus levels revealed that BPD demonstrated limited ability to provide timely service for any construction contract award, either new or with modifications. As a result, delays caused cost increases due to extended overhead and escalation.

BPD's default acquisition method for construction was design-bid-build, small business set aside. Although this method was appropriate for some types of acquisitions, it was not the most efficient method for major construction. An example was the Phase I construction of the AFRH-G Master Plan--the construction of a new resident wing for Building 1 valued at approximately $20M. A more cost effective approach for this project would have been a two-phase, best value source selection, design-build. This procurement method would have shortened procurement time, reduced contract administration and limited construction modifications. Additional construction contract procurement methods that should be considered for future procurements include life-cycle bidding and energy savings performance contracting.

Areas of Strength

The Chief Architect exhibited dedication and enthusiasm while providing highly effective support to AFRH employees and residents.

The effective use of AE IDIQ contracts to provide technical quality assurance when these services did not exist in-house.

Findings and Actions Required

None noted.

Recommendations

(HR-01 Recommendation): Establish formal policy and guidance between the Agency and Campus Operations to define authorities, roles and responsibilities.

(HR-02 Recommendation): Adopt DOD standards for SOW, RFP, specifications and cost estimates. DOD standards are available electronically over the internet to include Whole Building Design Guide (wbdg.org) and Construction Criteria Base.

(HR-03 Recommendation): Use expertise from other governmental agencies for specialty services and/or technical reviews. Examples include the Tri-Service Medical Agency (TMA) which specializes in the construction and restoration of medical facilities and the Army Corp of Engineers and/or Navy which have dedicated planning, architect and engineering technical experts.

(HR-04 Recommendation): For non-routine construction procurements, use other governmental agencies as sources of expertise. For example, the military services are experienced with a variety of design-build methods and energy saving performance procurement methods.

(HR-05 Recommendation): When AE services are contracted to provide project specific designs, expand the SOW to include economic analysis for alternative solutions. Also, perform facility condition assessments when needed to support the annual inspection program.

(HR-06 Recommendation): Post Agency generated plans, surveys and studies on a common portal to enhance access and use by each Campus Operations staff.

AFRH – GULFPORT

Recently, AFRH-G Campus Operations successfully completed an A76 study. Success was based on an effective use of manpower resources combined with a series of service contracts. Level loaded work, cyclic and preventive maintenance were accomplished by in-house personnel. Unique work, such as elevator certification and high voltage electrical distribution repairs, needed on a less frequent basis and requiring certification, licensing and continuing education, was contracted through specialty service providers.

Local AFRH-G policy and procedural guidance was well documented. Campus Operations personnel developed and used detailed SOPs for disaster preparedness and recovery, work order request management and motor transportation. AFRH-G was updating local directives and instructions, converting them from when AFRH-G was the Naval Home. Although local SOPs were well written, they neither included Agency terminology nor followed Agency directives. Additionally, in many cases, a local SOP encompassed several Agency directives.

Recently, the Agency completed a comprehensive AFRH-G Master Plan. Campus Operations personnel effectively integrated the master plan with their five-year capital improvements projects.

Campus Operations personnel conducted a monthly resident satisfaction survey covering employee attitude, courtesy and appearance, response time and work quality. Survey results indicated that Campus Operations personnel consistently met customer needs. Interviews with residents and staff indicated satisfaction with Campus Operations service and support. The "Sorry, I Missed You" program was noteworthy. This program featured a service notice with the employee's picture and phone number so the resident could call back, reschedule service and recognize the employee.

Campus Operations personnel were tasked with writing service and minor construction contracts. However, personnel were not provided training on contract specification writing and did not have a specification writing system to provide the most current standards. Therefore, they based specifications on previously awarded contracts and/or contractor and manufacturer recommendations. Additionally, contract quality assurance surveillance was performed by Campus Operations technicians and mechanics as collateral duties. Documentation of formal quality assurance surveillance training was lacking.

Campus Operations personnel established and maintained an Annual Inspection program that included a facility inventory, inspection schedule and general inspection category. However, standards and detailed checklists were not developed. For example, when conducting a roof inspection, documentation of subsystem inspections (I.e., flashings, counter flashings, pitch-pockets, penetrations, substrate, insulation and membranes) was required. These systems could then be benchmarked against industry standards with recommendations for maintenance, repair and/or replacement.

Recently, the Agency changed their maintenance management software from MP2, a client-based program, to 7i, a web-based program designed by DataStream. While this software conversion was completed in early 2005, the AFRH-G Maintenance Control Director (MCD) demonstrated a thorough understanding of the software's capabilities. The Agency supported AFRH-G with both 7i training and data conversion. Although the MCD used 7i extensively, Campus Operations would benefit if all supervisors used the software.

Campus Operations effectively used 7i to support Asset Inventory, Preventive Maintenance, Work Order and Supply and Materials program management.

> Asset Inventory: The asset inventory was comprehensive and included manufacturer data and work history for items such as pumps, motors, air handlers, doors and roofing. A complete work history on each asset was stored, allowing the MCD to execute trend analysis.

Preventive Maintenance: The asset inventory data base was linked to the manufacturer's recommended preventive maintenance checklist and included suggested materials.

Work Orders: Work orders were developed and tracked through the 7i software. Data collected included individual labor trades, required materials, contracts, time and costs. The data was indexed by work type such as facility maintenance, safety, Heating, Ventilation and Air Conditioning (HVAC) and resident request. However, the MCD did not use a standard of comparison when tracking work orders.

Supply and Materials: Supply and materials were tracked and inventoried for stock and non-stock items. This included bar-coding, suggested sources, cost and units of issue. The MCD maintained a well written receiving and distribution SOP. Inventories were bar-coded and logged into an inventory database enabling the MCD to track material inventory and usage trends. However, the supply room bar-code system was a stand-alone system and data was manually transferred to the 7i software.

Campus Operations personnel created and used a variety of custom reports that enabled statistical analysis of the programs described above. This capability was used to enhance work efficiency and highlight high-impact focus areas.

Campus Operations personnel established and used a highly effective Motor Transport and Vehicle Usage directive. They maintained a detailed trip and usage history. Additionally, use of golf carts versus fuel consuming vehicles provided an efficient transportation alternative.

Maintenance contracts over the government purchase card limit of $2,500 were forwarded to BPD for processing, including routine contracts such as an air handling unit replacement. According to interview testimony, lengthy processing time detracted from these efforts.

Campus Operations maintained an effective working relationship with a local Navy Seabee battalion. A detachment of Seabees was assigned to AFRH-G and completed small construction projects during training exercises. This resulted in an economical way for AFRH-G to execute construction projects where the only cost was materials. However, AFRH-G did not always benefit from the latest technologies and designs afforded by a professional engineer or architect. Moreover, in many cases, public law required alterations and/or conversions to be sealed by a registered professional.

Campus Operations personnel established and used a detailed Energy Management directive that enabled the MCD to manage the Energy Conservation program in a highly effective manner. The MCD maintained thorough documentation of measurable standards to include lighting levels, indoor air quality, temperature, relative humidity and equipment usage. Energy saving devices such as light sensors, motion detectors, and locked thermostats were used throughout the campus. The MCD managed the Energy Conservation program as a collateral duty, along with other duties such as the fire and safety officer. The amount of time required for training and

quality execution for these collateral duties required leadership attention and consideration of a full-time equivalent (FTE) position.

Utility rates were negotiated as part of a joint agreement by the Navy for the AFRH-G, Veterans Administration and Seabees. Utilities were under service contract for preventive maintenance and repair.

Areas of Strength

Dedicated and enthusiastic Campus Operations personnel provided highly effective support to the employees and residents; they demonstrated impressive quality customer support with their "Sorry I Missed You" program.

Campus Operations personnel effectively coupled manpower resources with the use of service contracts.

Campus Operations personnel managed a solid Trend Analysis program for predictive versus reactive maintenance.

Findings and Actions Required

None noted.

Recommendations

(HR-07 Recommendation): Provide appropriate training opportunities for Campus Operations personnel to include construction and maintenance inspection training, and service and contract specification writing training. Training should include available commercial software tools.

(HR-08 Recommendation): Develop a comprehensive Annual Inspection program that includes measuring findings against established baseline criteria. Each of the military services has developed computer based programs for consideration. For example, the Navy uses the Facility Readiness Evaluation System (FRES), which is a decision support application.

(HR-09 Recommendation): When AE services are contracted to provide project specific designs, expand the scope of work to include economic analysis for alternative solutions. Also, perform facility condition assessments when needed to support the annual inspection program.

(HR-10 Recommendation): Combine like functions into single service contracts. Current contracts are fragmented. For example, separate contracts for HVAC controls, cooling tower maintenance and HVAC equipment existed. Combining these contracts would reduce contract solicitations by BPD, costs through economy of scale and contract administration workload for the Contracting Officer Representative (COR).

AFRH – WASHINGTON

AFRH-W civil engineer functions were accomplished by contractors, with the exception of custodial work and central heating plant operations. As a result, AFRH-W was organized as a maintenance planning and contract management operation. The Campus Operations Director was well qualified with a solid civil engineer and public works background. The director had only been in place for approximately one year. Several key positions on the director's staff were filled as a result of Reduction in Force (RIF) actions, to include the supervisory maintenance contract and two COR surveillance specialists. Therefore, the position fills were not specialists in the civil engineer and/or contract management fields. Additionally, at the time of the inspection, a critical engineering technician position was vacant for over a year after two failed recruitment attempts.

Campus Operations did not establish a formal Annual Inspection program. The Campus Operations Director was working to build a program. In the interim, a Maintenance Action Plan was developed based on requests from other departments. The inspection program was a responsibility of the vacant engineering technician position. Additionally, AFRH-W did not maintain a comprehensive inventory of campus assets or established standards. The previous asset inventory was conducted in 1994. Moreover, non-invasive inspections were lacking in areas such as storm and sanitary lines, water lines and electrical power distribution. As a result, Campus Operations personnel did not proactively plan and conduct predictive maintenance--they operated in a reactive manner.

Work orders were processed using a client-based software program, MP2. As stated earlier, the Agency recently replaced MP2 with 7i, a web-based software program. However, AFRH-W had not transitioned to 7i. The maintenance management data in MP2 was adequate and used to track maintenance cost and conduct trend analysis. Although MP2 tracked required preventive maintenance tasks, sufficient detail was lacking.

Campus Operations personnel used the Construction Criteria Base software program available on the internet to write service and minor construction contract specifications. While this was a creative method, the Agency neither mandated its use nor that of any other specific system. The Agency also did not establish any quality control. As at AFRH-G, personnel were not trained on specification writing and sometimes found themselves out of their area of expertise.

Campus Operations provided contract surveillance for 39 different contracts with only two CORs. Several of the contracts were established in an inefficient manner, with overlap existing between services. For example, separate contracts for HVAC controls, cooling tower and HVAC energy plant maintenance existed with separate contractors. Problems in any one of these contracted areas could cause a failure in the air conditioning system. Campus Operations personnel acknowledged this inefficiency and were assessing the need for a single contract responsibility. Additionally, the CORs were over tasked and performed construction inspections

without proper training. Moreover, quality assurance surveillance plans (QASP) were not developed for any of the AFRH-W service contracts or construction task orders. The CORs were also tasked as a collateral duty to write the specifications for service and minor construction contracts.

Utility rates were negotiated as part of a joint agreement with other local government agencies. Utilities were under service contract for preventive maintenance and repair. Campus Operations personnel managed and maintained the campus boiler plant in a highly effective manner. However, AFRH-W did not establish an Energy Conservation program.

Area of Strength

The staff was dedicated and energetic and provided the best services possible for the employees and residents given resource constraints.

Findings and Actions Required

***(H-01 Finding):** AFRH-W did not develop strategies for maintaining cultural resources [historic buildings] and the methods used for compliance.

Finding Cause Code: Oversight

Observations: The Agency, through the land use development plan, contracted with an AE firm to produce a Phase 1 environmental cultural resource study and an inventory of assets documenting their historic significance. These studies were done IAW the Section 106 process and coordinated with governing agencies such as the State Historic Preservation Office. However, the study did not provide any recommendations on strategies for maintaining cultural resources or methods used for compliance. Random inspection of several facilities inventoried as historical revealed significant degradation, to include rusting decorative cast iron, rotting window sashes and sills, cracked stucco and rotting cornice work and cupolas. Sherman Hall had several completed improvements that were not in compliance with Section 106 process--asphalt replacement shingles in lieu of original slate and the use of window air conditioning units.

Actions Required: Commission a historic preservationist to develop strategies for maintaining cultural resources and compliance methods IAW 36 CFR 60.9. Also, the inspection team recommends researching alternate funding sources such as historical foundations, grants and/or DOD legacy programs.

***(H-02 Finding):** AFRH-W did not maintain an Energy Conservation program.

Finding Cause Code: Guidance

Observations: Campus Operations did not establish formal policy and guidance for an Energy Conservation program. No personnel were assigned energy conservation management responsibilities. Random facilities inspections revealed no energy savings devices such as motion detectors, light sensors and/or setback thermostats.

Actions Required: Establish an Energy Conservation program IAW Presidential Executive Order 13123. Management attention is needed to ensure energy and water audit, alternative energy sources and materials, and awareness training program elements are in place. The program should emphasize the use of energy savings performance and utility energy efficiency service contracts.

Recommendations:

(HR-11 Recommendation): AFRH-G recommendations are applicable to AFRH-W.

(HR-12 Recommendation): Assess the HVAC air circulation systems. Investigate American Society of Heating, Refrigeration and Air Conditioning Engineer (ASHRAE) makeup air requirements for individual resident rooms. New renovations did not provide for any makeup air. The current LeGarde Hall HVAC configuration was a central air circulation loop with individual room terminal air blending units. This type of system mixes individual room air into a common system increasing the potential for the spread of infectious disease.

(HR-13 Recommendation): Establish a program to measure in-door air quality to include CO2, relative humidity and temperature. Include as part of a formal employee and resident satisfaction and feedback program.

TAB I – SECURITY

OVERALL ASSESSMENT

The AFRH security assessment addressed local area threat assessments, physical security safeguards, training programs, manpower utilization, and electronic security systems. With one exception, no specific laws or DOD guidance governed AFRH security requirements. Therefore, this section contains only one finding, but does offer recommendations for enhancement of AFRH security operations.

AGENCY

In March 2005, a security operations specialist was assigned to provide Agency-level coordination of policy and guidance for security and investigative services, crime prevention and physical security. The Agency provided minimal formal policy or procedural guidance to the two campuses. AFRH-G and AFRH-W security chiefs were uncertain of the role that the security operations specialist played in their day-to-day efforts to formulate security programs at their respective locations.

Both campuses provided adequate security. Both AFRH-G and AFRH-W security chiefs solicited the assistance of local law enforcement agencies in conducting a site security/crime prevention survey of their individual campuses. However, the security operations specialist position description stated this person will "…inspect and evaluate the security operations of both campuses and recommend any needed corrective action."

Findings and Actions Required

***(I-01 Finding):** AFRH did not establish formal policy and guidance for baseline campus security standards.

Finding Cause Code: Guidance

Observations: The AFRH-G and AFRH-W campuses did not have Agency-level security standards addressing internal and external security measures, perimeter fencing requirements, training programs for both civil service and contract security personnel, and electronic security system use.

Actions Required: Develop and implement Agency-level security standards. Agency-level policy and guidance should be supplemented by the campuses to account for local concerns and requirements. While local environments must be taken into consideration, the inspection team recommends that baseline standards be established so administrative requirements and security upgrades at both locations can be programmed into future budgets. Furthermore, standardize the

Standard Operating Procedures (SOP) of both campuses in the areas of traffic enforcement, key control procedures and vehicle registration.
(24 U.S.C. § 415(c)(3)(a))

Recommendations

(IR-01 Recommendation): Recommend a thorough Agency-level AFRH security assessment for both campuses be conducted, documented and reported to AFRH senior leadership. Additionally, a location specific neighborhood threat analysis would benefit both campuses to enhance security force and senior leadership awareness of the primary types of crimes that are prevalent in those locales.

(IR-02 Recommendation): Develop an Agency-level directive to establish a standardized training plan for all security personnel that includes required documentation of prescribed training. Additionally, develop an annual training plan to facilitate training currency in critical areas such as CPR, use of force, safety and other areas deemed necessary by senior leadership.

AFRH – GULFPORT

AFRH-G employed a mix of civil service and contract security personnel for both exterior and interior security operations.

The security office and main gate were static posts manned 24 hours a day, seven days a week. The security office was located in the Building 1 main lobby and was the in-processing location for AFRH visitors. The main gate was located just inside the perimeter fence and within 40 yards of a four lane public road. While these posts had radios and telephones for communications, neither post had a duress alarm system.

A structured security guard training program which included both job qualification and in-service or recurring training was not fully developed. New civil service security personnel received a short on-the-job training session, typically with day shift personnel, prior to being assigned a particular shift. Contract security personnel received training through their sponsoring company.

In June 2005, the Gulfport MS Police Department conducted a security/crime prevention survey of the AFRH-G campus. Campus lighting, perimeter fence maintenance, exterior door security and closed circuit television (CCTV) camera deficiencies were noted. CCTV effectiveness was negatively impacted by poor lighting and obstruction due to overgrowth of bushes, shrubs, trees and/or limbs. Similar deficiencies were noted in a June 1999 report from the same police department.

Building 1, the main resident building, housed an alarmed Navy Exchange and Hancock Bank branch office. Security personnel demonstrated less than effective knowledge and awareness of

the alarm systems. Furthermore, the software program tying the bank alarm to the security office was removed from the computer that annunciated an alarm situation.

Areas of Strength

The Chief of Security developed and used an excellent "Use of Force" statement of understanding form for security personnel to read and sign.

Security personnel developed and used highly effective fire alarm/drill evacuation SOPs.

Findings and Actions Required

None noted.

Recommendations

(IR-03 Recommendation): Chief of Security work with senior leadership to correct the deficiencies noted in the Gulfport MS Police Department's 2005 security/crime prevention survey. Additionally, the chief should work to accomplish a neighborhood threat assessment.

(IR-04 Recommendation): Chief of Security maintain all security alarm system information on the Navy Exchange and Hancock Bank branch office and routinely contact these offices for policy and procedures updates or changes. Additionally, institute a process to routinely test facility alarm systems.

(IR-05 Recommendation): AFRH-G install an audible/visual type duress alarm system in the security office and main gate to facilitate response of emergency personnel.

(IR-06 Recommendation): An SOP or Agency directive be developed to formally establish a standardized training plan for all security personnel to include formal documentation of prescribed training subjects. Additionally, a quarterly, semi-annual, or annual training plan should be developed to facilitate training currency in critical areas such as CPR, use of force, safety, and other areas deemed necessary by senior leadership.

(IR-07 Recommendation): Once a neighborhood threat assessment has been accomplished (IR-01 above) and a security standard established by the Agency element security operations specialist, a reassessment of manpower position requirements should be accomplished.

AFRH – WASHINGTON

AFRH-W employed a mix of civil service and contract security personnel for both exterior and interior security operations. Total civil service personnel authorized was 15, which included the Chief of Security and Pass and Permits clerk. The remaining 13 security personnel were divided

amongst three eight-hour shifts providing coverage for the campus that was located on 270 acres of fenced land. In addition, contract security personnel were posted one-per-shift at the main gate and another was posted at the LaGarde Building Monday thru Friday, 2300 to 0700 hours and Saturday and Sunday, 1500 to 0700 hours. Security coverage of the campus was adequate, but limited due to manpower constraints.

The security desk sergeant and main gate were static posts manned 24 hours a day, seven days a week. Personnel used radios as their primary means of communication. However, neither post had a duress alarm system.

CCTV was used to monitor the main gate, Sheridan and Scott Hall lobbies, fitness center and security desk. Patrol coverage, whether on foot or motorized, was limited in all other areas of the campus due to manpower constraints. Over the previous five years, gradual reductions in security manpower authorizations had taken place. However, there were no indications that compensatory measures were implemented to offset the decrease in manpower. Based on the expanse of land that AFRH-W occupies, number of facilities in use and security response times, the inspection team was concerned with the adequacy of the campus security coverage.

Portions of the campus fence line were brick with wrought iron poles and barbed wire outriggers affixed atop the poles. The majority of the fence was normal gauge steel fence fabric affixed to poles with metal ties and outriggers affixed atop the poles. Portions of the fence were still considered adequate although there was severe rust on sections of both the wrought iron and fencing fabric. However, grounds maintenance in and around the southwest fence line required immediate attention. Large portions of this fence line were completely hidden by overgrown foliage, trees, and bushes which created significant security vulnerability. Tree limbs were allowed to grow up and over the fence extending outside the perimeter onto public sidewalk areas. Interior grounds had the same security vulnerability. Bushes, tree limbs, and shrubs were not properly trimmed, creating a high level of concealment for intruders.

The Chief of Security established a baseline security training program with SOPs and a master training task listing. Civil service security personnel were issued expandable batons and pepper spray canisters. Although initial training was completed for all current civil service security personnel, no refresher or additional training was developed for these two pieces of equipment. In some cases, personnel had not been trained on one or both of these items for two or more years. Furthermore, while training records were developed for civil service security personnel, documentation inconsistencies were noted in 8 of 10 records reviewed. The training records task listing had the trainers' initials but did not have the trainees' initials certifying or acknowledging completion of each training task list item.

Upon the request of the Chief of Security, the Metropolitan Police Washington DC Department (MPDC) conducted a physical security study of AFRH-W in June 2005. The study did not include prevalent crime information regarding adjacent neighborhoods.

Area of Strength

The Chief of Security developed comprehensive SOPs for use by the Security Investigations Division.

Findings and Actions Required

None noted.

Recommendations

(IR-08 Recommendation): Chief of Security meet regularly with the MPDC to receive neighborhood threat updates.

(IR-09 Recommendation): AFRH-W conduct a survey of the perimeter and interior foliage overgrowth and initiate steps to correct this vulnerability.

(IR-10 Recommendation): AFRH-W complete a site security survey with emphasis on identifying locations for additional CCTVs to enhance campus security.

(IR-11 Recommendation): Following completion of an Agency-level security assessment and neighborhood threat analysis, and establishment of a baseline security standard, conduct a thorough review of security manpower position requirements.

(IR-12 Recommendation): Chief of Security establish annual refresher training for security personnel who use the expandable baton and pepper spray canister; implement procedures to ensure trainees sign-off on each training task list item accomplished. Additionally, because the expandable baton is considered a lethal weapon, the inspection team recommends that a *use of force statement of understanding* form with signature be developed and used. This form should outline AFRH-W policies regarding use of force, use of the baton and the training required before it can be issued to security personnel.

(IR-13 Recommendation): AFRH-W install an audible/visual type duress alarm system in both the main gate and the security desk to facilitate response of emergency personnel.

TAB J – SAFETY

OVERALL ASSESSMENT

The AFRH safety assessment addressed program management required under 29 U.S.C. § 657, *Occupational Safety and Health Protection*. In addition to public law, safety responsibility was promulgated by Presidential Executive Order 11612, *Occupational Safety and Health Programs for Federal Employees*, which directed federal agencies to lead the way in establishing a safe and healthful workplace. The assessment included facility operations, safety training, performance management and emergency preparedness and response requirements.

Overall, the AFRH-G and AFRH-W Safety Managers administered effective but separate Occupational Safety and Health programs. The programs provided sound surveillance and prompt abatement of identified hazards. While some Americans with Disabilities Act (ADA) compliance progress was noted at AFRH-G, continued management emphasis was required to ensure ADA compliance remained a top priority. In addition, Risk Management Incident Report coordination, safety training documentation and recreational-related safety deficiencies were noted.

AGENCY

Although AFRH did not establish a standardized Agency-level safety program, the AFRH-G and AFRH-W Occupational Safety and Health programs were well managed and implemented IAW 29 CFR 1910, *Occupational Safety and Health Standards*, 29 CFR 1960, *Federal Employee Occupational Safety and Health* and 29 CFR 1926, *Safety and Health Regulations for the Construction Industry*. The Agency would benefit from having a standardized plan that addressed policy and procedures, committee requirements and safety management responsibilities.

Area of Strength

Knowledgeable Occupational Safety and Health managers at both campuses proactively administered their safety programs.

Findings and Actions Required

None noted.

Recommendation

(JR-01 Recommendation): AFRH senior leadership develop and publish an Agency-level directive to standardize the Occupational Safety and Health programs for both campuses.

AFRH – GULFPORT

The Occupational Safety and Health manager developed and used a detailed Occupational Safety and Health Management Plan (OSHMP) and manual to ensure compliance with CFR requirements. The comprehensive OSHMP provided guidance and procedures to reduce and/or eliminate those threats which did not meet the applicable elements of OSHA, National Fire Protection Association (NFPA), National Institution for Occupational Safety and Health (NIOSH), and other federal, state, and local safety standards. The manual provided a framework for maintaining a safe and healthful working environment and identified the tracking process for accidents, injuries and illnesses occurrences and causal factors. It identified the responsibilities for AFRH-G organizational elements.

Strong infection control awareness was in place to ensure an effective Blood Borne Pathogens Exposure Control Plan. In addition, the laundry physical plant met the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) guidelines for ventilation and separation of soiled and clean linen areas. Effective control measures were in place to include identification of appropriate locations for placing soiled linen and use of a contract service.

Disabled residents faced challenges with access to and egress from facilities, primarily Building 1. Resident rooms in the building were 90 square feet in size. Personnel with wheelchairs had limited mobility in their rooms; they were unable to fully turn around or evacuate without assistance. Also, campus bathrooms were not designed to accommodate ADA residents.

Two planned ADA initiatives were coupled with major construction projects. One initiative was embedded in Phase I construction of the AFRH Master Plan – the construction of a new resident wing for Building 1. Phase I construction and building renovations were designed to increase the resident room size to meet ADA requirements and provide adequate living space. Plans for JCAHO mandated ADA construction precautions will be executed when a Phase I construction timeline is received. The other planned ADA initiative involved the renovation of the Building 1 ballroom and lobby bathrooms. Following a 2003 Navy ADA survey, a description of work was developed in July 2003. However, this initiative was associated with Phase III of the AFRH Master Plan. The 2003 survey also addressed public restrooms, chapel, post office, pool and other designated public areas. AFRH-G did make some progress to address specific ADA concerns. Interim measures included the construction of ADA ramps on Building 5 and new access doors for the chapel.

Documentation of mandatory OSHA safety training accomplishment was lacking. AFRH-G utilized the Silver Chair Training System, an online computer-based training curriculum with authorship lesson plans modules. The system design provided an efficient training data base for monitoring mandatory safety training. However, full system implementation was not established.

Findings and Actions Required

***(J-01 Finding):** AFRH-G facilities had limited disability access.

Finding Cause Code: Safety

Observations: Throughout the campus, means of access to and egress from facilities were limited for disabled individuals. In the event of fire or other emergency evacuation, buildings did not provide quick egress IAW NFPA 101, *Life Safety Code*. NFPA requirements mandate that structures have two separate means of egress. To ensure Building 1 compliance, one egress exit must be a stair tower made of fire-resistant material, leading directly to the outside at grade (ground) level. A stair tower was part of the Phase 1 construction for Building 1.

Actions Required: Continue efforts to review construction design plans to ensure compliance with ADA requirements. Plans must include ramps for use by pedestrians, wheelchairs and motor powered vehicles. All access provided by aisles, passageways or corridors shall be convenient to every occupant. Ensure compliance with applicable NFPA 101, NFPA 99, *Standard for Health Care Facilities*, and American National Standards Institute (ANSI) A117.1, ANSI A10 requirements.

***(J-02 Finding):** AFRH-G mandated OSHA training was not properly managed.

Finding Cause Code: Safety

Observations: AFRH-G supervisors did not ensure required OSHA safety training was documented.

Action Required: All levels of supervision implement and enforce local policy directives. Coordinate and manage safety training to ensure compliance with 29 U.S.C § 657 and AFRH-G *Occupational Safety and Health Manual*.

***(J-03 Finding):** The AFRH-G pool facility had structural deficiencies.

Finding Cause Code: Safety

Observations: The bottom of the pool had protruding drain pipes. Also, the pool platform surface area had protruding fixtures. Finally, the disability ramp did not meet design standards.

Action Required: Minor deficiencies were corrected prior to the inspection team's departure from AFRH-G. The remaining deficiencies were identified on a work request for contracted maintenance service. Ensure pool area meets ANSI/NSPI Standard 1-1991.

***(J-04 Finding):** The AFRH-G skills craft shop was not in compliance with woodworking CFR requirements.

Finding Cause Code: Safety

Observations: The craft shop was a resident controlled area. The building was a deteriorated old home with limited egress and it lacked a proper ventilation system. In addition, a possible noise abatement problem existed. Other chemical, physical, biological and ergonomic concerns were noted.

Action Required: Establish a new location that meets NFPA 101 and 29 CFR 1910.213, *Woodworking machine* requirements. Since woodworking activities introduced the primary hazardous conditions, an industrial hygiene review should be conducted for collocation of activities.

***(J-05 Finding):** The AFRH-G auto hobby shop did not meet U.S. Environmental Protection Agency (EPA) Clean Water Act of 1977 requirements.

Finding Cause Code: Equipment

Observations: Facilities were not designed with an oil separator for changing fluids.

Action Required: Adopt mitigation strategies for oil and fluid changes to ensure compliance with EPA requirements.

Recommendation

(JR-02 Recommendation): Prescribe policy and procedures to determine the hazard severity for an identified hazard or deficiency. Develop an AFRH policy directive to establish a standard criterion based on 29 U.S.C., CFR Part 1960, Presidential Executive Order 12196, and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Long-Term Care Accreditation Standards.

AFRH – WASHINGTON

As at AFRH-G, the Occupational Safety and Health manager developed and used a detailed OSHMP and manual to ensure compliance with CFR requirements. The comprehensive OSHMP provided guidance and procedures to reduce and/or eliminate those risks which did not meet the applicable elements of OSHA, NFPA, NIOSH, and other federal, state, and local safety standards. The manual provided a framework for maintaining a safe and healthful working environment and identified the tracking process for accidents, injuries and illnesses occurrences and causal factors.

The Occupational Safety and Health manager established a flexible "safety fair" program to ensure personnel received both annual and recurring safety training. The fair provided an informal avenue to administer safety, health, environmental and security training to supervisors, employee and local community volunteers. AFRH-W managers ensured training programs and technical publications complied with applicable OSHA requirements.

New construction projects met ADA building design requirements IAW with NFPA 101 and ANSI A117.1-2003 standards. Means of egress were appropriately established and designated.

Findings and Actions Required

***(J-06 Finding):** The AFRH-W Risk Management Incident Reporting process and coordination were lacking.

Finding Cause Code: Oversight

Observations: Incident reporting procedures deficiencies were noted and timelines for coordination were not met. Reporting between medical staff, workers' compensation office and safety manager was not effectively managed. For example, the medical staff initiated several incident reports in May 05. However, the safety office did not receive the reports until July 05. Because documentation was forwarded to and maintained at the contracted HR function at BDP, Parkersburg, WV, timely mishap investigation and trend analysis were not accomplished.

Actions Required: Conduct Risk Management Incident Reporting training to ensure compliance with 24 U.S.C § 416, 29 CFR 1960 and 1904 and AFRH Directive 1-3, *Incident Reporting*.

***(J-07 Finding):** The AFRH-W fishing pond grounds and surrounding structures were not properly maintained.

Finding Cause Code: Safety

Observations: Significant safety deficiencies were identified regarding the deterioration of structures at the pond grounds. Both the fencing and pond wall were deteriorating. In addition, the pond grounds were located in a remote area and lacked an emergency alert device.

Actions Required: Either close or adopt risk mitigating strategies for restricted use of the campus pond grounds until compliance with 29 CFR 1910, *Walking Surfaces*, and 36 U.S.C., Part 2, *Resource Protection, Public Use and Recreation*.

***(J-08 Finding):** The AFRH-W golf course did not have a constructed walkway or approved storage location.

Finding Cause Code: Safety

Observations: The golf course required a walkway, constructed surface, for entrance into the main facility. Also, the area above the locker room ceiling was used as an unapproved storage location. Items were stored on the plywood and plastic ceiling and two-by-fours (no load capacity/fall hazard).

Actions Required: Construct a walkway that meets NFPA 101 and 29 CFR 1910.22 requirements to prevent injury to patrons and employees. Remove stored items from locker room ceiling area and provide approved storage space for golf course as required.

Recommendation

(JR-03 Recommendation): AFRH install a wired or wireless emergency alert device at the fishing pond grounds to alert security in the event of an emergency at this remote location.

TAB K – MEDICAL

OVERALL ASSESSMENT

For healthcare services, AFRH was not subject to DOD directives in most areas. AFRH-G and AFRH-W were more than just retirement communities. Although the campuses provided healthcare, they were unlike the medical treatment facilities routinely visited by any military service's inspection agency. Also, few, if any, civilian counterparts served as useful benchmarks for comparison. To avoid Joint Commission on Accreditation of Healthcare Organizations (JCAHO) redundancy and to balance the "findings" pointed out in the JCAHO accreditation reports, the inspection team did the following: 1) verified follow-up in key healthcare service areas which JCAHO requested improvement; 2) annotated issues in service opportunity; 3) noted updates and changes made by the facilities; 4) recommended avenues and options for improvement; and, 5) reviewed other non-JCAHO associated aspects involved with potential healthcare sensitivities involved in these special facilities.

AFRH HEALTH CULTURE

Healthcare Eligibility and Requirements: Residency applicants for admission and medical care were functionally able to live independently and free of psychiatric disorders. New arrivals entered as Independent Living (IL) residents. Assisted Living (AL) and Long-Term Care (LTC) units offered higher levels of support to established residents whose needs increased over time. With few exceptions, new residency applicants were rejected if they already needed AL or LTC support. Within limits, AFRH thus offered IL residents the emotional security of compassionate care tailored to changing individual needs in a single facility for the remainder of their lives.

Facility Accreditations: AFRH-G and AFRH-W participated voluntarily, but separately, in triennial JCAHO Accreditation Surveys. The two facilities had independently elected surveys under a now similar set of JCAHO standards. According to 24 U.S.C. § 418, the COO shall endeavor to secure for each campus a nationally recognized civilian accreditation, such as JCAHO. AFRH-G was surveyed in March 2005 and awarded full accreditation in August 2005 for three years under JCAHO standards for Ambulatory Health Care, AL and LTC. AFRH-W was surveyed in October 2005 and awarded full accreditation in January 2006 for three years under JACHO standards for Ambulatory Health Care and LTC.

JCAHO Quality Reports for AFRH-G (13 October 2005) and AFRH-W (31 January 2006) are included in *Section IV* of the report.

Resident Living Facilities: Despite their organizational linkage, AFRH-G and AFRH-W were distinctly different facilities in obviously different settings. Resident capacities and occupancy rates as of the July 2005 inspection are shown below:

Armed Forces Retirement Home – Capacity and Occupancy Rates (values rounded)						
Residency Category	**AFRH-G**			**AFRH-W**		
	Capacity	**Residents**	**Occupancy**	**Capacity**	**Residents**	**Occupancy**
Independent Living	522	509	98%	1017	811	80%
Assisted Living	56	51	91%	70	64	86%
Dementia Care	n/a	n/a	n/a	20	20	100%
Long-term Care	26	18	70%	173	124	72%
Facility Totals	**604**	**578**	**96%**	**1260**	**999**	**79%**

At AFRH-G, the resident population appeared generally fit, active and well off for their age. The population consisted of 507 male and 71 female residents. The average age was 78 for male and 80 for female residents. They lived together in a cohesive community within a single facility, Building 1, just a modest walk from the beach. Healthcare services were coordinated under an Executive Management Committee (EMC) that served as the oversight body to all campus medical functions. A relatively small proportion of AFRH-G residents required AL (approximately ten percent) or LTC support (approximately four percent). AFRH-G continued to face increasingly moderate limitations in meeting healthcare needs as residents were further replaced by Korea- and Vietnam-era veterans who required more focused support. IL residents continued to live in very small rooms (90 square feet with half baths) that lacked effective wheelchair access. Although there was limited physical space at AFRH-G for expansion of AL or LTC capabilities, proposed projects included a Memory Support Unit to care for demented residents. Other strategic options outlined in the AFRH-G Master Plan included several progressive Building 1 wing expansions. Phase I expansion included construction of new resident rooms with 400 square feet. Future expansion was not designed to increase resident capacity.

In contrast to AFRH-G, facilities at AFRH-W had much more built-in capacity to serve the complex needs of current and future residents. Space existed on site for potential additions of buildings or use of existing structures if renovation and/or budget allowed. The AFRH-W Master Plan included several proposed changes to Scott Hall over the next few years. On average, AFRH-W residents were more diverse and debilitated, and less financially secure. The population included 926 males and 73 female residents. The average age was 78 for male and 81 for female residents. Approximately 19 percent of the population required LTC or AL services, which they received in a modern, separate facility (LaGarde) as well as in several reserved beds within in the IL facility (Scott Hall). Recently, more stringent spacing issues surfaced with the opening of a new AL ward in Scott Hall due to the closure of Pipes Hall (due to electrical and plumbing problems) which formally housed AL and LTC residents. One floor in LaGarde had a Dementia section which was secured for those patients requiring special attention.

There were many well-intended healthcare initiatives at AFRH-G and AFRH-W. However, the staff professionals who seemed willing to keep residents' interests as a priority were faced with budget demands and organizational challenges. These issues affected some key areas that required a continued support or focus to effectively maintain the efficiency, safety and delivery of necessary healthcare and services.

AGENCY

Since the last triennial inspection, the AFRH COO worked hard to make healthcare services at both campuses more attractive and responsive to resident needs. At times, there was less responsiveness to resident needs as noted in surveys and inspection interviews. The fast-paced changes created by organizational restructuring, downsizing and repair of the stated negative financial spiral generated resistance and affected "satisfaction" in many areas. AFRH leadership was and continued to be challenged to identify and meet the changing needs (physical, social and psychological) of future residents even though a strategic plan and campus Master Plans existed.

Findings and Actions Required

Note: The attached JCAHO Quality Reports provide a Summary of Quality Information and an Organization Quality Report History. JACHO Accreditation Surveys list specific findings and discrepancies; survey and follow up documents are maintained by the AFRH.

Recommendations

(KR-01 Recommendation): AFRH COO continue establishing central policy and guidance to standardize (or articulate differences in) the involvement of both campuses in JCAHO accreditation.

(KR-02 Recommendation): AFRH COO coordinate the strategic plans for both campuses addressing how each will accommodate the changing healthcare needs of future residents.

AFRH – GULFPORT

AFRH-G Medical Care: Medical staffing levels at each campus reflected the different resident populations that each served. The AFRH-G Healthcare Services Department included 83 staff personnel. Under a recently renewed contract, three physicians staffed AFRH-G from the Health Assurance provider network located in Jackson MS. Additional physicians were actively recruited. The improved new contract required clinician availability for 30 hours per week for outpatient services and ten hours per week for inpatient (AL and LTC) services. A provider was on-call 24 hours a day, seven days a week for house patient care issues. However, provider staffing and scheduling concerns impacted consistency for provider presence in the clinic. Night emergency response for injuries, accidents or deaths was adequately covered by 911 Emergency Services. Provider staff consisted of the following: 1 Dentist; 1 Dental Hygienist; 2 Dental

Technicians; 1 Pharmacist; 1 Pharmacy Technician; 15 Clinical Nurses (RN); 1 Certified Nurse Practitioner (CNP); 9 Licensed Practical Nurses (LPN); and 33 Nursing Assistants (NA). Of the total 58 authorized nursing positions, three vacancies existed. Nursing service and access to care demographics are annotated later in this summary.

Based on DOD directives and public law, AFRH-G met the overall "medical" requirements for its accreditation survey. As noted earlier, in March 2005, JCAHO conducted an on site accreditation survey at AFRH-G. The several performance areas that addressed insufficient or unsatisfactory standards compliance required formal follow-up with the Joint Commission. In July 2005, AFRH-G submitted a written progress report to JCAHO on areas deemed insufficient or substandard. In August 2005, JCAHO rendered a decision for accreditation with full standards compliance.

Scope of medical services provided at AFRH-G included Internal Medicine/Family Medicine, Psychology, Nutrition, Social Work, Rehabilitation, (physical, occupational and speech therapy), Dentistry and Podiatry. There were no Diagnostic services other than dental x-rays. As noted during the previous triennial inspection, medical records were in binder/folder form with plans to implement computer-based records in the future. Pain assessments were accomplished on all residents; this was virtually nonexistent during the last inspection.

For AFRH-G residents, access to medical care was excellent and tailored to individual needs. Typically, seven to ten patients were seen daily per physician in the clinic. These circumstances were far better to those afforded residents in comparable civilian institutions. Scheduled outpatient care was available in the Ambulatory Care Clinic five days a week. Walk-in patients were offered the same access and seen on a same-day basis dependent on triage priorities and the set schedule. Virtually all IL residents used the onsite Ambulatory Care Clinic for acute illness or injury. Despite recent reductions to correct excessive AFRH layering, the facility's AL and LTC provider staffing was more than adequate and appropriate when compared to outside civilian agency requirements. IL residents had the option of using an AFRH staff physician as their primary care provider. A review of records, augmented by resident interviews, found that 70 to 80 percent of IL residents continued to choose this option. The remaining IL residents used other providers at local military or civilian medical facilities. AL and LTC residents received primary care from their respective ward physicians. When needed, the majority of acute inpatient care and specialty outpatient service was provided by nearby Keesler Air Force Base Medical Center (KAFMC). Medical data was accessible and easily followed up through KAFMC's computerized Composite Healthcare Computer System (CHCS).

As validated in the 2005 JCAHO Accreditation Survey, key medical programs at AFRH-G met or exceeded community standards for quality of care. Results from a 2005 AFRH Resident Survey indicated that residents expressed only moderate levels of satisfaction with local medical care. No interim sentinel events had occurred since the 2005 JCAHO survey. In 2004, several residents (mainly through AFRH-W) generated letters of complaints on the scope of services, quality of care, quality of life and/or living conditions. The 2005 JCAHO survey investigated

the applicable medical care issues and noted them to be essentially unsubstantiated. Another follow-on unannounced "for-cause" JCAHO survey was accomplished 8 June 2005. At that time, JCAHO reviewed specific complaint allegations related to the eight areas under Accreditation Policies and Procedures. Again, no substantiated findings were announced. The inspection team noted that AFRH-G leadership was committed to having more open forums and monthly Town Hall meetings. These sessions offered an avenue to discuss resident-concern topics and helped mitigate possible emotional ties to obsolete or stagnated aspects of healthcare services.

Annual birth month assessments of resident health and vigilant daily observations by staff continued to be the surveillance tools for detecting declines in health or functional status. Significant effort was made to maximize and maintain independent functioning, within safety limits. The CNP conducted annual resident assessments that included a physical exam, depression screening and an overall functional assessment. The assessment also included a comprehensive chronic disease index evaluation and nutritional review. In addition, it covered all aspects of periodic health maintenance including colorectal and gender-specific cancer screening, vaccinations and substance abuse assessment. A psychologist evaluated residents with evidence of depression or behavioral management issues. Immunization programs for influenza and pneumococcal pneumonia were in place with evidence of acceptable compliance.

Residents with known diabetes were assigned to a nurse case manager and the dietician. JCAHO's recent records review revealed good documentation of quarterly glycohemoglobin and microalbumin determinations, annual retinal and podiatry exams, and semi-annual lipid profiles. Separately, residents receiving coumadin anticoagulation therapy were enrolled in a physician-managed clinic at AFRH-G, regardless of their primary care provider. This strategy enhanced compliance and maintenance of therapeutic goals.

Institutional Occupational Health programs continued to comply with applicable standards. Employee training programs for hepatitis B vaccination, latex allergy, tuberculosis surveillance and blood-borne pathogen exposure education were established and compatible with standards promulgated by OSHA and recommendations from the Centers for Disease Control and Prevention. However, tracking and documentation deficiencies were noted. Also, most operating instructions and policies were either obsolete or in draft format. Finally, Executive Committee meeting minutes documentation was minimal.

A significant number of residents continued to use alcohol and tobacco. Most were veterans from an era when both substances were socially accepted and actively encouraged. AFRH-G health promotion efforts included tobacco cessation and alcohol awareness programs. Admission assessments (diabetic screening, mental health status and medication use) and annual physicals addressed these items in the following manner:

> Tobacco Cessation activity included semi-annual educational efforts through the Keesler Air Force Base (KAFB) Health and Wellness Center. AFRH encouraged residents to

voluntary enroll in a six-week support course along with the initiation and management of adjunctive medication regimens. Ongoing support and treatment were tailored to individual needs. Some success was claimed with these efforts, although substantiating data was not readily available. AL and LTC smokers (and demented residents) were presently taken to a designated smoking area to ensure that fire safety was maintained. IL residents were permitted to smoke on only two floors; these floors had available smoke detectors. Efforts to push for regulating smoking in this DOD facility were met with resistance from those veterans addicted both psychologically and physiologically to smoking.

Alcohol Abuse Awareness training was offered quarterly to residents. It focused on the dangers and warning signs of alcohol abuse and addressed appropriate evaluations and interventions when alcohol abuse was manifested by a resident. Training effectiveness data did not exist. The medical staff noted concerns about the ease with which residents (including AL and LTC residents) obtained alcohol at AFRH-G (nearby bars, stores, on-site Navy Exchange, casinos, et al). Residents were discouraged from using alcohol in their rooms. Review of incident reports regarding falls and injuries of residents indicated no trend or association with alcohol-related events. This was a substantial improvement from the previous AFRH Triennial Inspection. This trend was a rough indication of the success of current policy revisions, awareness briefings and improved staff interactions in the Health Promotion program. The overall incidence of falls at AFRH-G did not appear to be significantly higher than the average at comparable facilities.

Since the last triennial inspection, AFRH-G became better equipped to care for residents suffering from dementia. Severe psychiatric disorder, behavioral disorder and active alcoholism residents were referred out to appropriate local facilities or enrolled at AFRH-W for special care. These efforts improved compassionate holistic care to residents throughout the continuum of their remaining life – including their decline in later years into frailty and dependency. In addition, the proposed new Memory Support Unit scheduled to be completed in 2008 supported this goal.

AFRH-G Nursing Services: The nursing staff composition far exceeded required local and nationally established staffing models for AL and LTC nursing facilities. The local area civilian agency requirement standard for direct nursing staff involvement and care for LTC patients was 2.8 hours per patient per day; AFRH-G boasted an average of 4.92 hours. The local area civilian agency requirement standard for direct nursing staff involvement for AL patients was 1.4 hours per patient per day; AFRH-G boasted an average of 2.15 hours. Minimum nurse coverage for day, evening and night shifts is outlined below:

AFRH-G Nursing Services		
	Assisted Living	**Long-Term Care**
Day Shift	2 RNs, 6 LPNs, 5 NAs	7 RNs, 3 LPNs
Evening Shift	1 RN, 2 LPNs, 4 NAs	2 RNs, 1 LPN, 5 NAs
Night Shift	1 RN, 2 LPNs, 2 NAs	1 RN, 1 LPN, 4 NAs

According to the AFRH-G staff, most RNs and LPNs remained on staff for three to five years. This was a vast improvement from the last triennial inspection. However, higher pay at the nearby Veterans Administration Medical Center (VAMC) and other local medical facilities enticed potential exodus. NAs continued to remain longer because their pay was slightly higher than that offered at local alternatives. Moreover, the long hiring process for civil service employees led to many viable candidates taking positions elsewhere.

As of January 2005, AFRH-G hired a new Administrative Healthcare Services Director, who together with an associate director provided nursing care oversight. LTC and AL senior nurses managed their own nursing unit functions with oversight by the Chief, Nursing Manager. A Credentialing Manager maintained centralized credentialing verification for nurses and support staff, verified state licensure and maintained competency files. National guidelines for staff in geriatric LTC settings called for licensed nurses to acquire 30 Continuing Education Units (CEU) every two years and for NAs to acquire 12 CEUs annually. CEU training was focused on care of the chronically ill and disabled, geriatric nursing, dementia, depression and communication. According to the 2005 JCAHO Accreditation Survey, the staff met these standards. Competency verification was standardized from unit to unit allowing for the annual review or periodic revision of competency requirements. This effort matched training needs of the individual with assessed needs of the facility. The organization established facility-wide training requirements for nursing personnel and formal orientation for newly assigned personnel occurred.

The Performance Improvement (PI) coordinator handled the nursing education and Quality Assurance (QA) functions for the facility.

Nursing personnel were represented on the EMC. Recent JCAHO concerns were addressed through the incorporation of Nursing Services under the Healthcare Services department.

AFRH-G Pharmacy Services: Adequate pharmaceutical care services supported residents and medical staff. Pharmacy services were well integrated into all aspects of the retirement community. In addition, the staffing, resources and hours of operation for the pharmacy were sufficient. A pharmacist was on call weekends and after hours. At the time of this inspection, the pharmacy staff was newly assigned; the pharmacist was less than two weeks into her tenure and the technician was in place for several months. Drug use eval, medication errors/adverse action, medication counseling and profile review data for AL and LTC patients was provided monthly to the Quality Assurance (QA) Committee. Following the 2005 JCAHO Accreditation Survey, these actions were documented in the monthly minutes.

For inpatient services, the AFRH-G pharmacy used a manual data base to maintain patient medication profiles--this was also noted in the last two triennial inspection reports. Manual monthly renewals, medication administration records (MAR), discharge medications and medication profiles increased the chance of errors when transcribing and dispensing orders. The pharmacy staff acquired a new automated system to electronically manage AL and LTC medications, but required training had not yet occurred. Once the system is implemented, the pharmacy may require an outside consultant and/or KAFMC support to assess needs and offer management options.

For outpatient pharmaceutical services, a Memorandum of Understanding (MOU) existed between AFRH-G and KAFMC. The MOU provided cooperative processing of prescriptions for AFRH-G residents who were eligible Military Healthcare System (MHS) beneficiaries or Secretary of the Air Force designees (this effectively encompassed all residents). The AFRH pharmacy staff had direct access to the KAFMC CHCS pharmacy module for new or refill prescription entries. Couriers transported filled prescriptions from KAFMC to the AFRH-G pharmacy each weekday. The prescriptions were then checked and dispensed by AFRH-G without charge. AFRH-G filled approximately 1,000 prescriptions per month. This was a volume increase of 30 percent since the previous triennial inspection

AFRH-G Dental Care: Dental staffing was adequate for the resident population. The Dentist was in place for three years and spent a significant time in the operatory providing restorative rather than preventive care. He averaged approximately 190 patient visits per month. The Hygienist averaged approximately 24 patient visits per week, providing cleanings, exams and bedside oral health care evaluations.

The Gulfport dental providers were somewhat isolated from their peers in other local government medical facilities. Emphasis was needed to establish closer referral affiliations with the nearby Navy Branch Dental Clinic in Gulfport or the Dental Clinic at KAFB. Additionally, emphasis was needed to take advantage of in-service training opportunities at these clinics.

Locally developed dental computer programs were adequate to meet current dental practice requirements. Commercial off-the-shelf products remained available at reasonable cost to allow for progress notes, charting, treatment planning and recall programs.

Required bi-annual radiographic checks for defective lead aprons documentation was in place and improvements in autoclave spore testing procedures were noted.

AFRH-G Nutrition Services: Nutrition care far exceeded minimum standards of care as defined by the American Dietetic Association for adult nutrition in ambulatory and LTC services. Nutrition programs (i.e. hydration and food/drug interaction) were well established and provided exceptional service to residents.

Two full-time licensed and registered Dietitians provided daily nutrition care to residents. Licensure and registration of both dietitians was maintained in the Healthcare Services department. The dietitian's duties included the care and monitoring of AL and LTC residents. The other served primarily as the Nutrition Services Manager for both campuses, and also managed the execution and performance of the food service contract. Each Dietitian was well versed and cross-trained to cover in the other's absence.

New residents received an initial nutrition assessment. When needed, medical nutrition therapy, drug interactions and dietary interventions were provided including nutrition education. Peer review auditing was used to assure competency and quality care and audit results were reported quarterly to the QA Committee.

The dining facility contractor provided adequate staffing for the preparation and service of more than 1,500 meals per day, in addition to snack service. Food was available 24 hours a day, with the IL residents having open access to a facility-funded snack bar. The facility also provided subsistence for residents on regular and modified diets and those requiring specified enteral nutrition. The menus were well balanced and reflected resident preferences. Dietary concerns were highlighted in a recent resident survey. However, inspectors deemed that recent changes in dining facility operations were made in the best dietary interests of the residents. Meal preparation was well planned. A "Compnutrition" software program was used to determine and stabilize food purchases, assess use and waste, and provide caloric calculations. There was no stipulated need for portion control with individuals. Also, complaints on the resident survey about food temperature were mitigated by an available microwave oven. Dietary awareness was emphasized through forums, Town Hall meetings, television and paper advertisements and/or word-of-mouth.

The kitchen was maintained in an extremely clean condition. Food service monthly inspection report documentation revealed minimal repeat write-ups.

Backup electrical power to the kitchen was provided by an emergency generator. Emergency services and food supplies were set for three days normally and seven days during hurricane season.

Medical Executive Oversight: EMC minutes and Progress Reports documentation required attention. While executive staff members were well aware of the 2005 JCAHO Accreditation Survey improvement issues, recent meeting minutes lacked detail on action plans, discussion and issue resolution. For example, minutes lacked reference to newly established Quality Reviews (delegating responsibilities and reporting of quality measures and performance) and JCAHO Binder (referencing the improvement action plans). Detailed EMC minutes and Progress Reports documentation was needed to ensure continuity if key personnel became unavailable during critical phases of process development.

Area of Strength

Nutrition services personnel maintained an exceptional focus on resident dietary needs and kept AFRH-G on track to become a National Center for Diabetes Education.

Findings and Actions Required

Note: The attached JCAHO Quality Reports provide a Summary of Quality Information and an Organization Quality Report History. JACHO Accreditation Surveys list specific findings and discrepancies; survey and follow up documents are maintained by the AFRH.

Recommendations

(KR-03 Recommendation): AFRH-G EMC establish a more definitive policy on risk management incident reporting with coordination through the AFRH-G safety office.

(KR-04 Recommendation): AFRH-G EMC develop efficient oversight to provide means to balance personnel tasks, document processes and actions, and manage healthcare functions.

(KR-05 Recommendation): AFRH-G Medical Director implement measures to ensure adequate physician coverage and take steps to improve the level of oversight care at the campus.

(KR-06 Recommendation): AFRH-G Director, with assistance from AFRH-W, develop and/or acquire training to implement a more effective and safe unit dose pharmacy system for AL and LTC residents.

(KR-07 Recommendations): AFRH-G dental services establish closer referral affiliations with the nearby Navy Branch Dental Clinic in Gulfport or the Air Force Dental Clinic at KAFB. In addition, make efforts to take advantage of in-service training opportunities at these clinics.

AFRH – WASHINGTON

AFRH-W Medical Care: As at AFRH-G, access to medical care for residents at AFRH-W far exceeded that at generally comparable civilian nursing home facilities. The AFRH-W Healthcare Services department had 148 staff personnel including three direct hire physicians. Clinician availability was good for outpatient services; AFRH-W conducted daily floor/ward rounds on the inpatient (AL and LTC) services. A provider was on-call 24 hours a day, seven days a week for house patient care issues. Night emergency response for injuries, accidents or deaths was adequately covered by 911 Emergency Services. The provider staff consisted of the following: 1 Dentist; 1 Dental Hygienist; 1 Dental Technician; 1 Pharmacy Technician (1 vacancy); 23 Clinical Nurses (RNs) (2 vacancies); 2 Certified Nurse Practitioners (CNPs); 18 Licensed Practical Nurses (LPNs with 8 vacancies); and 88 Nursing Assistants (NAs with 12 vacancies). Included and/or separated personnel positions such as Medical and Nursing

Directors, assistant directors, educators, and trainers that played vital roles in resident healthcare and management made up the remaining mix of staff. Planned measures were underway to fill vacancies in nursing. Based on resident population and clinic demand, the inspection team identified the following potential shortages: 1 Dentist; 1 Pharmacy Technician; and 1 Laboratory Technician.

Based on DOD directives and public law, AFRH-G met the overall "medical" requirements for its accreditation survey. As noted earlier, in October 2005, JCAHO conducted an on site accreditation survey at AFRH-W. The several performance areas that addressed insufficient or unsatisfactory standards compliance required formal follow-up with the Joint Commission. In January 2006, AFRH-W submitted a written progress report to JCAHO on areas deemed insufficient or substandard. In January 2006, JCAHO rendered a decision for accreditation with full standards compliance.

Scope of medical services provided at AFRH-W included Internal Medicine/Family Medicine, Psychology, Nutrition, Social Work, Rehabilitation, (physical, occupational and speech therapy), Dentistry and Podiatry. There were no Diagnostic services other than dental x-rays. As noted during the last triennial inspection, medical records were in binder/folder form with plans to implement computer-based records in the future. Management of outpatient records required attention. The loss of IL resident records occurred routinely when they were taken to local medical facilities.

Seventy to eighty percent of IL residents used the Scott Hall Ambulatory Care and Community Health Clinic for their primary care services. The clinic offered scheduled weekday clinics and morning sick calls. The remaining IL Living residents used other providers at local military or civilian medical facilities.

AL, LTC and "Specialty Care" Dementia Unit residents were managed as inpatients with an assigned provider team that included a physician and/or CNP. For resident admissions, credentialed providers performed histories and physical examinations. Pain assessments were accomplished on all residents; this was virtually nonexistent during the previous AFRH Triennial Inspection.

In addition to services provided by the campus physicians, the staff from Walter Reed Army Medical Center (WRAMC) conducted several on-site specialty clinics. Clinics included ophthalmology, urology, podiatry, dermatology, speech and psychiatry. Separately, AFRH-W operated its own full-time physical and occupational therapy departments, along with part-time optometry services. Eyeglasses fabricated by a DOD facility in Virginia were provided to residents free-of-charge. After-hours emergency care was provided 24 hours a day, seven days a week by on-site emergency medical technicians.

Most tertiary care and other specialty services were available at WRAMC and a nearby VAMC. Convenient shuttle service was offered between these facilities several times per day. Additional area treatment facilities included Bethesda Naval Hospital, Washington Hospital Center and Providence Hospital. However, their distance precluded routine referrals unless requested for specialty care such as dialysis. The proposed closure of WRAMC created significant concern due to a potential increase in patient load at the VAMC as a shift in census occurred.

AFRH-W offered residents adequate quality of care. Review of credentials files revealed that providers who performed care were appropriately licensed and credentialed. Outpatient and inpatient records reflected appropriate health maintenance activity in diabetes care, immunizations, cancer screening, functional and substance-abuse assessments and anticoagulation therapy management. In these areas, the staff effectively administered policy and procedures. Although a level of performance improvement documentation was evident, resident outcome data was not available.

AFRH-W offered a full spectrum of employee Occupational Health programs coordinated by a certified Occupational Health Nurse. Employee training programs for hepatitis B vaccination, tuberculosis surveillance and blood-borne pathogen exposure were established and compatible with standards promulgated by OSHA and recommendations from the Center for Disease Control and Prevention.

Similar to AFRH-G, residents at AFRH-W were afforded adequate health promotion education along with appropriate interventions for tobacco use and alcohol abuse. Pre-placement exam and audiometry, spirometry and medical surveillance evaluation services complied with OSHA standards.

AFRH-W Nursing Services: Historically, AFRH-W experienced difficulty attracting nursing personnel. But, this situation improved somewhat with increased compensation packages even though pay lagged behind that at local civilian and government medical facilities. To keep nursing staff levels adequate to meet resident needs, AFRH-W relied on the use of local community nurses.

The local area civilian agency requirement standard for direct staff involvement and care for LTC patients was 3.2 hours per patient per day. In contrast to AFRH-G, AFRH-W based its nurse staffing on patient census and maintained an average in the following manner for its separate facilities (daily averages placed beside floor locations):

AFRH-W Nursing Services						
Shift	Assisted Living		Long-Term Care – LaGarde (L)			
	Scott Hall (1.77)	LaGarde (2.25)	L3 (3.09)	L4 (3.62)	L5 (3.09)	Dementia (3.8)
	FTE	FTE	FTE			
Day	2.4 RNs/LPNs, 3.6 NAs	1.6 RNs/LPNs, 2.88 NAs	3.2 RNs/LPNs, 8 NAs	3.2 RNs/LPNs, 10 NAs	3.2 RNs/LPNs, 8 NAs	1.6 RNs/LPNs, 4.4 NAs
Evening	2.4 RNs/LPNs, 3.6 NAs	1.6 RNs/LPNs, 2.88 NAs	3.2 RNs/LPNs, 8 NAs	3.2 RNs/LPNs, 10 NAs	3.2 RNs/LPNs, 8 NAs	1.6 RNs/LPNs, 4.4 NAs
Night	1.6 RNs/LPNs, 2.4 NAs	1.6 RNs/LPNs, 2.16 NAs	3.2 RNs/LPNs, 5.33 NAs	3.2 RNs/LPNs, 8 NAs	3.2 RNs/LPNs, 8 NAs	1.6 RNs/LPNs, 3.2 NAs

The local area civilian agency requirement standard for direct staff involvement/care for AL patients was 2 hours per patient per day; AFRH-W maintained averages of 1.77 for Scott Hall (AL residents requiring less focused care) and 2.25 for LaGarde. These numbers were comparable to AFRH-G averages. However, as stated above, local community nurses were used to provide coverage and keep hours near the required standard. This generated a financial burden on the overall AFRH-W medical budget. Healthcare Services expense comprised approximately 49 percent of the annual AFRH budget.

The Nursing Director provided strong leadership and ensured nursing competency by closely monitoring the facility's staff education and training programs. Additionally the director and her staff effectively reorganized the department and balanced resident supervision and care based on need. Unlike the findings from the previous JCAHO survey, CNPs routinely conducted patient rounds with physicians and actively participated in developing medical record progress notes and patient management plans.

The Performance Improvement (PI) Committee set the foundation for overall Healthcare Services oversight and activities. This committee's function was employed only for the Healthcare Services department and there was little evidence of PI data transfer between departments. Nurses were offered baseline PI training. Collected data was prioritized and aggregated to improve and/or enhance resident care. Effective risk management for infection control was in place. A review of PI minutes revealed little discussion of important issues such as the long-planned AL facility expansion into Scott Hall and potential closure of WRAMC. Also, as the AFRH resident population ages, the transfer of AFRH-G residents to AFRH-W will increase the demand for skilled nurses.

AFRH-W Pharmacy Services: The pharmacy technician staff provided satisfactory support to the residents and medical staff. AFRH-W maintained a unit-dose dispensing system to support AL and LTC inpatient residents. Dispensing, monitoring and review were accomplished through a contract "Neighborcare" system that routinely reported to the PI Committee. The dispensing process mitigated the previous labor-intensive, inefficient and error-prone system reported in the previous triennial inspection. Prescription orders averaged 2,650 prescriptions per month and

inpatient medication order turnaround time averaged an acceptable four hours. The staff strictly monitored and appropriately stored drugs in a double-locked narcotics container.

At AFRH-W, the inspection team found limited patient medication counseling documentation for ambulatory IL residents. However, the pharmacy and medical staff reported very few medication errors or adverse drug events to the PI Committee. The pharmacy technician staff served a large patient population as previously outlined. The technician primarily provided a custodial medication service for dispensing maintenance medications with a maximum 90-day supply issued to outpatient residents. Other than managing prescription delivery from WRAMC, which occurred about twice per week, the pharmacy technician appeared to have little involvement in the provision of any clinical services. AFRH-W filled approximately 1,525 outpatient prescriptions per month. Patients ultimately received their medications without cost, mostly from the nearby VAMC or WRAMC, through an outdated MOA. The retirement home outpatient pharmacy budget only provided funds to purchase a small emergency supply of pharmaceuticals for use by residents. The AFRH-W pharmacy staff and nurses had direct access to the CHCS pharmacy module for prescription entry.

AFRH-W Dental Care: The Dentist was in place for several years and spent significant time providing restorative rather than preventive care. She averaged about 155 outpatient and 19 inpatient visits per month and 1,253 outpatient and 126 inpatient procedures per month. For the patient load observed, justification existed for an additional Dentist position.

The Hygienist provided the resident community with cleanings and exams. In addition, time was provided for bedside AL and LTC visits for oral health care evals. She averaged about 57 outpatient and 25 inpatient visits per month and 352 outpatient and 72 inpatient procedures per month. As with the dentist, a heavy outpatient patient load existed. The addition of a second part-time hygienist would help AFRH-W better meet community standards. Moreover, the dental staff would benefit from enhanced communications with the WRAMC, VAMC and Fort Meade MD dental clinics.

Dental accountability was negatively impacted by the lack of an electronic scheduling and patient census/visit log. The current hand-written log was difficult to read and comprehend. At times, a 25 percent cancellation rate for resident appointments existed.

AFRH-W Nutrition Services: In contrast to AFRH-G, the inspection team received little positive feedback from residents and staff regarding food quality. Upon review, the inspection team determined that Nutrition Services gradually improved in the six-month period prior to the inspection. The improvement was attributed to a new in-place contract. Observation revealed that food service and management provided wholesome and nutritious products. Food service met generally accepted food service industry practices. Expenditures and food quality were controlled and monitored to ensure that positive trends in improvement continued. Stock inventory controls continued to improve and a three-day stock of emergency supplies was maintained. Repairs and replacement of old or broken kitchen machinery were taking place to

resolve previous repeat triennial inspection findings. However, maintenance and repair of kitchen walls, ceiling and floors required management attention.

Although entomology services were in place, pest control issues continued to require focused management attention. Sanitation and food preparation discrepancies were being resolved.

Dietitians were assigned for the IL residents and for the 208 AL and LTC residents. The dietitians provided effective preventive dietary management and residents were referred to a dietitian as required. Nutrition screening, nutrition intervention and education were part of resident primary care (preventive or maintenance). As at AFRH-G, approximately 25 to 30 percent of the residents were diabetic. Accommodations for initial evaluation and screening of each new IL resident were accomplished.

Dietary and clinical nutrition training and documentation were managed in an adequate manner. Since the previous triennial inspection, improvements in the above areas were noted.

Medical Executive Oversight: A strong PI Committee existed. Service areas were well represented on the committee. Documentation revealed that executive staff members were well aware of JCAHO improvement issues. Meeting minutes documented action plans, moderate discussion and resolution of issues. Quality reviews (delegating responsibilities and reporting of quality measures and performance) and JCAHO referencing were evident.

An assessment of planned patient flow in the new Scott Hall clinic identified pharmacy security, infection control and safety concerns. A pharmacy window allowed sight of visible, un-secured drugs. Floor rugs were located in the lab and patient exam room areas. Finally, a clinic hallway only allowed wheelchair, particularly motorized, access in one direction with little room for walking patients to pass.

Areas of Strength

Professional and dedicated dieticians created a well-focused, flexible dietary plan for IL, AL and LTC residents.

Performance Improvement/Environment of Care Committee provided effective oversight and continuity of vital medical programs.

Findings and Actions Required

Note: The attached JCAHO Quality Reports provide a Summary of Quality Information and an Organization Quality Report History. JACHO Accreditation Surveys list specific findings and discrepancies; survey and follow up documents are maintained by the AFRH.

Recommendations

(KR-08 Recommendation): AFRH-W Healthcare Services Director develop an effective outpatient record tracking system to account for lost or misplaced IL resident records

(KR-09 Recommendation): AFRH-W Healthcare Services Director follow-up with JCAHO on potential sentinel events to ensure clarification on issues.

(KR-10 Recommendation): AFRH-W Healthcare Services Director update outdated Memorandums of Agreement with local medical care facilities.

(KR-11 Recommendation): AFRH-W Nutrition Services Director continue resolving food preparation sanitation and kitchen maintenance deficiencies and ensure focused food service training and oversight.

(KR-12 Recommendation): AFRH-W Healthcare Services Director continue focused assessments in the nursing staff and AL and LTC needs areas.

(KR-13 Recommendation): AFRH-W Performance Improvement Committee establish a definitive policy on risk management incident reporting and coordinate with the AFRH-W safety office.

(KR-14 Recommendation): AFRH-W and AFRH-G Healthcare Services Directors work to improve the flow of information and Performance Improvement measures between the two campuses.

(KR-15 Recommendation): AFRH-W Healthcare Services Director assess the need to add an additional Dentist and a part-time Hygienist to better meet community standards. Furthermore, enhance communications with the WRAMC, VAMC and Fort Meade MD dental clinics.

TAB L – ESTATE MATTERS

OVERALL ASSESSMENT

Congress first established a home for ill or disabled soldiers in 1851 under, *An Act to found a Military Asylum for the Relief and Support of invalid and disabled Soldiers of the Army of the United State*s. The asylum was funded through appropriations and other means, including "all monies belonging to the estates of deceased soldiers, which are now, or may hereafter be unclaimed for the period of three years…" Today, AFRH still receives unclaimed monies or property from the estate of deceased residents of the Home. (24 U.S.C. § 420)

Currently, when a resident dies, the Agency relinquishes the will to the executor or next of kin (NOK) and safeguards personal effects (including motor vehicles) until removal by an executor or legal representative can be arranged. In the majority of cases property is promptly removed. At the end of the three-year period, if the property remains unclaimed, AFRH may retain the property for the facility or dispose of it through sale, donation, or in the case of items deemed valueless through destruction. (24 U.S.C. §420(b)) Both campuses typically donated personal items left by residents to non-profit organizations. Donation of items to a non-profit organization, such as Goodwill Industries, appeared to be sound business practice in cases where the value was minor. Both campuses performed estate matter duties and responsibilities in a satisfactory manner and had, with one exception, complied with 24 U.S.C. § 420.

AGENCY

Both campuses cited 24 U.S.C. § 420 and the Agency supplemental guidance, AFRH Instruction 2-6B, 30 March 2004, *Estate Matters*, as the governing guidance for the disposition of effects and unclaimed property program. However, the Agency was in the process of rewriting supplemental guidance to 24 U.S.C. § 420 to include, but not be limited to, storage fees for deceased resident property not dealt with by the executor or legal representative. It is tentatively scheduled to be published before the end of CY 05.

Findings and Actions Required

None noted.

AFRH – GULFPORT

AFRH-G was appropriately safeguarding deceased residents' property, to include maintaining vehicles in a separate secured location. In most cases, the executor or legal representative claimed the decedent's property within a reasonable time.

Area of Strength

24 U.S.C. § 420 directs facility Directors to retain, safeguard and dispose of the estate and personal effects of deceased residents. The AFRH-G campus met this requirement through the establishment of separate storage areas for both deceased resident privately owned vehicles (POV) and personal effects. Placing personal effects in a separately maintained and secured area ensured accurate accountability of all possessions until they were claimed or disposed of following the three-year storage period.

Findings and Actions Required

None noted.

AFRH – W ASHINGTON

At the AFRH-W campus the Chief of Resident Affairs was responsible for administering decedents' affairs. He indicated wills were given to the executor or legal representative at the time of the resident's death and not delivered to the court. 24 U.S.C. § 420(a)(1) requires wills or instruments of a testamentary nature involving property rights in AFRH's possession at the time of death be turned over to the court of record. AFRH believed wills involving only personal effects of the deceased (i.e., clothing, books, vehicles and other items of a personal nature) did not have to be delivered to the court. However, a recent opinion of the District of Columbia Court of Appeals interpreted 24 U.S.C. § 420(a)(1) to clearly require AFRH to take certain steps when a resident dies; specifically, to promptly deliver the will to the appropriate court. *In Re Estate of Couse,* 850 A.2d 304 (2004). We believed this judicial interpretation of the statutory language sufficiently supported delivery of the will to the court.

Procedurally AFRH-W followed AFRH Instruction 2-6B, 30 March 2004, *Estate Matters*, and the deceased rooms were secured until the executor or legal representative could be contacted and arrangements made to remove personal effects. Removal of personal items in the decedents' rooms was prompt alleviating the need to establish secure storage for personal effects. However, information provided by a resident led to the discovery of four POVs of deceased residents parked in various locations around the AFRH-W campus. These vehicles were in various states of disrepair and there did not appear to be any policy or guidance in place to ensure their security. The Chief of Resident Services was not aware these vehicles existed when initially queried. Subsequent discussions with Agency-level officials indicated that vehicles were not moved to a secure location due to the potential for claims by the estate.

Findings and Actions Required

***(L-01 Finding):** The AFRH-W Chief of Resident Services did not file deceased residents' wills with the proper court IAW 24 U.S.C. § 420(a)(1), "A will or other instrument of

testamentary nature involving property rights executed by a resident shall be promptly delivered, upon the death of the resident, to the proper court of record."

Finding Cause Code: Oversight

Observations: The AFRH-W Director of Resident Services stated wills were turned over to the estate's executor or legal representative upon the death of the resident. There was no requirement in the current or draft AFRH policy that required the director to deliver wills to the court. By providing the executor or legal representative with the will, AFRH-W believed they absolved themselves of any further legal involvement with the probate proceeding, thus avoiding any expense or manpower expenditures.

Action Required: The AFRH-W Chief of Resident Services must comply with 24 U.S.C. § 420 and deliver wills to the proper court.

Recommendation

(LR-01 Recommendation): The AFRH-W Chief of Resident Services should identify an exclusive location to store the vehicles of deceased residents. Such a location would ensure accountability until POVs are claimed or disposed of following the three-year storage period.

TAB M – SERVICES

OVERALL ASSESSMENT

Enthusiastic, customer-friendly personnel at AFRH-G and AFRH-W professionally managed the Recreation, Leisure, and Wellness (RLW) programs. The programs provided a wide and creative variety of activities that enhanced residents' morale and kept them active and healthy. Recreation facilities, with few exceptions, were clean, effectively managed, well equipped and safe. While both campuses developed their own standard operating procedures, they lacked standardization. In addition, minimal Agency-level policy and guidance existed.

AGENCY

The Agency did not have a recreation expert on staff to provide oversight of recreation programs. In addition, it had not established standardized recreation policy and guidance for the campuses. In a brief to the inspection team, the Agency introduced a plan to improve business success which was termed "The Model." The Model identified eight separate goals necessary for the Agency's successful transition to the future, to include establishing one set of standards, policies, and procedures. This goal had not yet been accomplished in the RLW area.

Findings and Actions Required

***(M-01 Finding):** Agency-level standardized policy and guidance for AFRH RLW programs were lacking.

Finding Cause Code: Oversight

Observations: RLW policy and guidance were locally generated and lacked standardization between the two geographically separated campuses. AFRH-G and AFRH-W maintained comparable RLW programming such as fitness centers, wood shops and auto crafts centers, but operational procedures for these activities were not consistent.

Actions Required: Establish standardized and detailed policy and guidance for RLW programs at both campuses to facilitate oversight and management of these activities and enhance customer safety.

AFRH – GULFPORT

The RLW program was managed by a Director of RLW, six full-time civil service employees, and resident volunteers. Programs were well marketed and customer participation and use of facilities and programs was good.

The following narratives describe AFRH-G RLW activities and programs:

Library: The Library was clean, organized, and stocked with a wide variety of books, periodicals and resource materials to include computers with internet access. The Library was manned by resident volunteers on a minimal basis and was open 24 hours a day, seven days a week. Check-out of books and other materials by residents was accomplished using the honor system with little problem.

Computer Lab: Computers were placed strategically throughout the recreational areas for resident use to gain access to the web, study, conduct business, and play computer games. Classes were available for individuals who wanted to learn basic computer skills.

Fitness Center: The fitness center was open 24 hours a day, seven days a week. There was a wide variety of strength-training and cardiovascular equipment supporting a variety of fitness needs for the elderly population. The facility depended on other residents and AFRH staff members to monitor customers using the facility. Safety features included a wall-mounted telephone positioned near the main entrance and two emergency "Code 7" wall-mounted punch buttons. The buttons, when pushed, alerted administration, security and medical personnel of a potential medical emergency.

Bowling Center: A two-lane bowling center with automated scoring and pin setting capabilities was clean, well lit and staffed by resident volunteers.

Hobby Shop: The hobby shop was located in a building that was formerly a residential structure. The building was modified by both residents and Campus Operations personnel to accommodate wood-working machines and separate work areas for arts and crafts activities. However, its design did not effectively meet current needs. The facility supported a variety of hobbies to include wood-working, lapidary/metal-working, paint and finishing, and small arts and crafts development. Several significant safety and Americans with Disabilities Act (ADA) concerns were noted and addressed in Tab J.

Auto Hobby Shop: The auto hobby shop was a small open-bay building with attached awnings that covered two parking spaces. These spaces were used by residents to perform minor maintenance and repairs on their POVs. The facility was clean and stocked with an assortment of automotive tools and equipment. It was staffed by resident volunteers who enforced safety, dispersed tools, and assisted residents with repairs. One U.S. Environmental Protection Agency (EPA) concern was noted and addressed in Tab J.

Outdoor Swimming Pool: The outdoor pool area was an attractive and well-maintained facility manned by contracted seasonal life guards and residents certified in First-aid and Cardiac Pulmonary Resuscitation (CPR). A policy required there be two or more people present at all times in the event no lifeguard was on duty. Safety concerns were noted and addressed in Tab K.

Greenhouse: In the past, the greenhouse was maintained by a full-time gardener. However, it had fallen into disrepair after the gardener position was eliminated. Resident use of this facility was sporadic and attempts by Campus Operations personnel to clean and upgrade it did not improve its use rate.

Dining Operation: The dining room was well lit and clean. It provided ample space between tables for residents with wheel chairs or other walking aids. The décor of the dining area was an aging military motif. Condiment stations were located throughout the dining area and residents placed trays and dishes on a conveyor belt located at the rear of the dining room when finished. Overall, the facility met the needs of the residents.

Bar Operation: The bar operation offered a wide variety of beer and spirits. Equipment located behind the bar was clean and in good working order. Smoking was permitted in the lounge and a specified smoking area just off the recreation area was located immediately next to the bar. The décor in the bar/lounge area was worn but functional. Pricing was very competitive with off-campus operations. The bar operation had been in place since 1995 and it provided the Residents' Fund with one percent of gross earnings monthly. However, at the time of the inspection, a current contract was not in place.

Tours: The RLW program offered residents a variety of outings and tours. Tours included visits to the Washington DC area where residents were afforded lodging at AFRH-W at minimal cost. Other tours included trips to local attractions and entertainment venues.

Area of Strength

The RLW staff demonstrated exceptional teamwork and dedication to service. Their involvement and concern for resident well being was noteworthy. There was a spirit of cooperation between the staff and different Campus Operations personnel during special events. As a result, residents were provided with the utmost in service, attention, and assistance.

Findings and Actions Required

None noted.

Recommendations

(MR-01 Recommendation): AFRH management enter negotiations with the bar operation contractor to establish a formal contract that would increase the monthly stipend to the Residents' Fund.

(MR-02 Recommendation): Post fitness center emergency procedures, written in large script (24 font or greater), by the phone located adjacent to the fitness center entrance.

(MR-03 Recommendation): For fitness center "Code 7" buttons, conspicuously mark and label "Emergency Use Only" to ensure residents and visitors can find the buttons and understand their intent.

(MR-04 Recommendation): AFRH management consider removing the existing greenhouse or downsizing the facility to match the use rate.

AFRH – WASHINGTON

The RLW program was managed by the Chief, Leisure and Wellness Division, ten full-time civil service employees and 65 resident volunteers. Overall, qualified and professional RLW staff members provided residents with quality leisure activities.

In May 2005, the RLW staff conducted a survey of residents to determine their satisfaction with and use rate of various recreational activities. AFRH received 288 responses to the survey. When asked to rate customer service, 84 percent of respondents rated it above average or better. When asked to rate recreational activities, 75 percent of respondents rated activities above average or better. When asked to rate facilities, 70 percent rated the facilities above average or better. The most used recreational facilities were the library, fitness center, and computer lab.

The following narratives describe AFRH-W RLW activities and programs:

Library: The library was managed by a full-time librarian and staffed by resident volunteers. The library was large, well stocked, and provided a comfortable setting with ample chairs and quiet areas for residents to read or study.

Computer Lab: Several well-equipped computer rooms were available to residents providing opportunities to engage in computer games, internet access, and word processing. One of the computer rooms was reserved for the regular offering of computer classes instructed by off-campus volunteers.

Fitness Center: The fitness center was managed by a full-time fitness center manager and a resident volunteer. The center hosted a wide variety of strength-training and cardiovascular equipment that was well spaced and in good operating condition. The facility was opened 24 hours a day, seven days a week. The facility had a telephone located in the corner of the room, opposite the manager's office, as well as a security camera that provided real-time video to campus security. Each locker room had a sauna that was locked and carefully monitored to ensure resident safety.

Bowling Center: The fitness center manager provided oversight management for the six-lane bowling center which was staffed by resident volunteers. The center was well maintained with adequate lighting and ventilation. It was supported by up-to-date scoring and pin setting technology. Tournaments and special events were scheduled monthly.

Wood-working Shop: The shop was staffed by four resident volunteers who reported directly to the RLW chief. The volunteers performed all of the wood cutting services as well as instruction and assistance to customers as requested. The shop was well maintained and had an adequate selection of tools, machinery, instructional material, and supplies.

Ceramic Shop: The shop was managed by a full-time shop manager and several resident volunteers. The shop was clean, spacious and well equipped. Residents with on-going projects had 24-hour access to this operation on an as needed basis.

Auto Craft Shop: The ceramic shop manager provided oversight for the auto craft shop and its two resident volunteers. The shop was clean, well equipped and well organized providing customers with an opportunity to perform minor maintenance and repairs on their POVs. One-on-one classes were provided by resident volunteers and there was a car wash stall available to residents at no cost.

Fishing Ponds: The fitness center manager provided oversight of the two resident fishing ponds. The ponds and surrounding property had deteriorated over time. Significant safety concerns were noted and addressed in Tab J.

Garden Plots: The fitness center manager provided oversight management for the garden plots assigned to residents. Approximately two acres of campus land were set aside for resident gardening activities. Several storage sheds stocked with gardening tools and equipment were available for the residents.

Golf Course: The course was a nine-hole course managed by the Chief of Leisure and Wellness Division who supervised contracted golf course operations and maintenance. The club house was small and the resident locker area was small, cluttered, and unventilated. Several safety concerns were noted and addressed in Tab J.

Dining Facilities: There were two contracted dining facilities located on the Washington campus. The dining room at the LeGarde Building boasted a more contemporary motif that was pleasant and inviting with a well organized serving line, refreshment area, and salad bar. The main dining facility located in Scott Hall was an older and much larger operation. The Scott Hall dining facility doubled as a community room for dances and other social events. Both the dining room décor and kitchen equipment were old and worn. Tables were widely spaced allowing residents easy access to the facility.

Bar Operations: The bar operation was contracted to the Army Air Force Exchange Service (AAFES) and consisted of a full-service bar and grill with a pool table and dart board located in an adjacent game room. The operation was well maintained and the manager had initiated new programs and venues to entice customers.

Area of Strength

The AFRH-W RLW program boasted a variety of well managed and equipped activities for residents. Staff members were professional and motivated to provide the best service possible to campus residents.

Findings and Actions Required

None noted.

Recommendations

(MR-05 Recommendation): AFRH-W management place emphasis on quality assurance procedures to monitor the performance of golf course contractors. Several contractor performance discrepancies were noted regarding the golf course. These discrepancies were immediately rectified by the Chief, Leisure and Wellness Division.

(MR-06 Recommendation): AFRH-W install a severe weather warning system at the golf course to ensure players are alerted to potentially dangerous weather conditions. The contractor used a small hand-held air horn to notify players of inclement and/or dangerous weather conditions. The use of the air horn was neither effective nor efficient.

(MR-07 Recommendation): AFRH-W use a wired or wireless emergency alert device at the resident gardening area that would alert security in the event of an emergency at this remote site.

(MR-08 Recommendation): AFRH-W install an additional surveillance camera in the fitness center adjacent to the current camera to remove blind spots directly under the ceiling mounted camera.

(MR-09 Recommendation): AFRH-W re-institute the requirement for ceramic shop customers to notify security when they enter and exit the shop after hours. This practice was once in place but had since been eliminated.

(MR-10 Recommendation): AFRH-W provide steel-toed shoes to the auto craft shop volunteers to limit potential foot injuries.

SECTION III – ADDITIONAL INFORMATION

KEY PERSONNEL:

NAME	RANK	OFFICE	PHONE
(b)(6)	AD-00-00	Chief Operating Officer	(b)(2)
	AD-00-00	Chief Financial Officer	

INSPECTION TEAM:

AREA INSPECTED	INSPECTOR/DSN PHONE	RANK	AFRH POC
Team Chief	(b)(2),(b)(6)	Col	
Deputy Team Chief		Lt Col	
Senior Management		Lt Col	(b)(6)
Human Resources Management		GS-13	
Admissions/Eligibility		Capt	
Financial Management and Analysis		GS-12 GS-13 GS-13 GS-12	
Records Management		CMSgt	
Privacy Act Freedom of Information Act		CMSgt	
Information Technology		MSgt	
Contracting		GS-14	
Civil Engineering		GS-14	
Security		CMSgt	
Safety		MSgt	
Medical		Col	
Mortuary Affairs		GS-13	
Services		Major GS-13	
Legal		Major	
DoD/IG Observer		GS-13	
NAVINGEN Inspector		Capt/ USN	
USA/IG Inspector		GS-13	

REPLY INSTRUCTIONS

1. PDUSD (P & R) will transmit the report to the Congress within 15 days of receipt and to the COO, AFRH for appropriate action. The COO is required to address all identified findings required to PDUSD (P & R), with a copy to the AFIA/FOI and DOD/IG, within 90 days following receipt of the PDUSD (P & R) transmittal.

2. PDUSD (P & R) will respond to the COO, AFRH, with a copy to AFIA and DOD/IG within 30 days to indicate whether findings are closed or remain open and what follow-up action is still required. AFRH has 30 days to respond. This process continues until all findings are closed. AFRH should identify one focal point for replies to PDUSD (P & R). Include enough detail in each reply so OSD can decide whether to close the finding or keep it open. If reply action is not complete, describe progress and include an estimated completion date. Include AFRH OPR in last line of the reply. If the finding is beyond AFRH's ability to solve, describe action taken to get assistance. Forward replies under a cover letter from the COO, AFRH to Pam.Crespi@osd.mil with subject titled: AFRH Update.

3. Report Disposition. See Administrative Procedures and Records Disposition Schedule.

DISTRIBUTION LIST

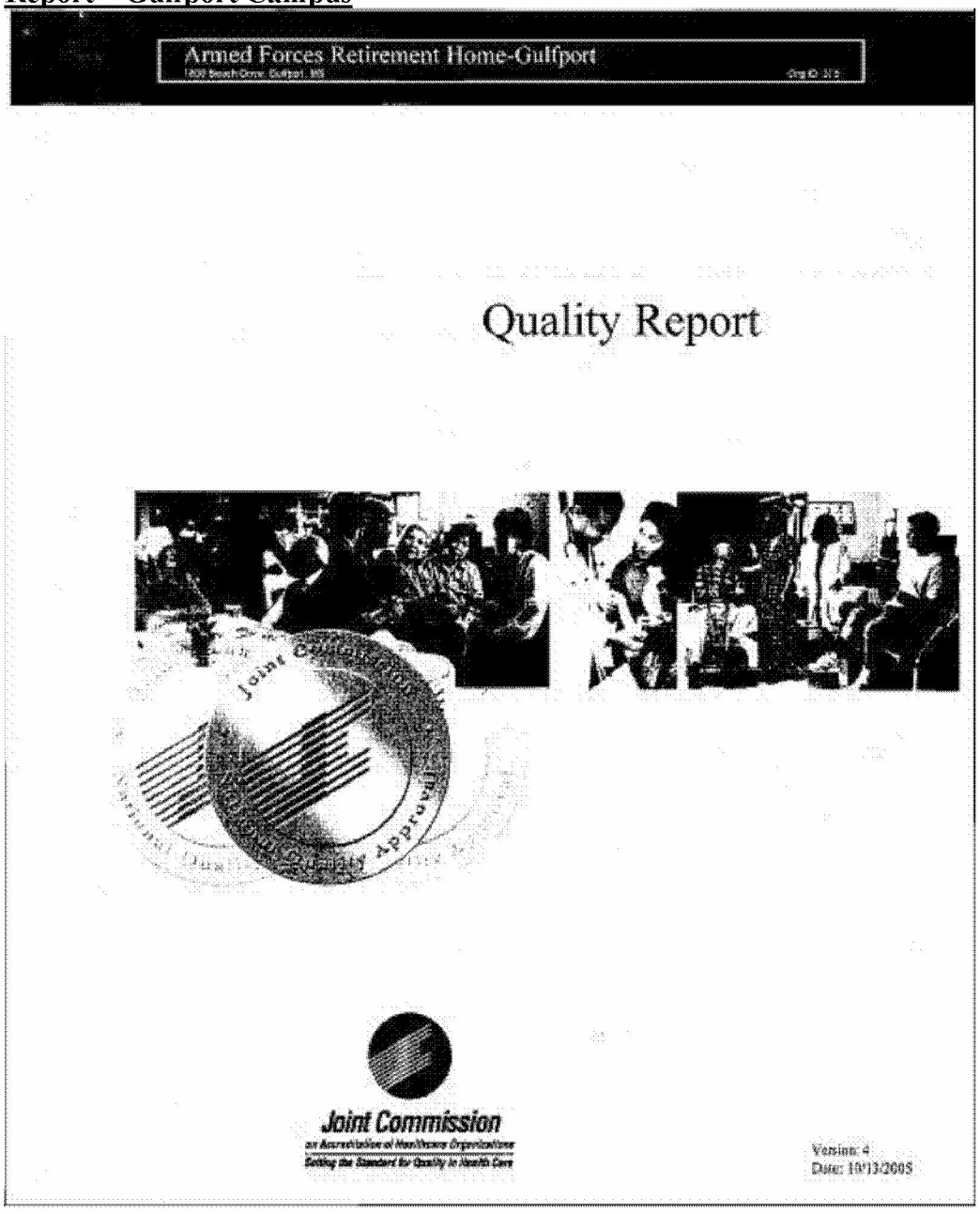
PDUSD (P & R)	1340 Air Force Pentagon	Washington DC	20330-1340
OSD/MC & FP	4000 Air Force Pentagon	Washington DC	20330
AFRH	3700 North Capitol St NW	Washington DC	20011
DOD/IG	400 Army Navy Drive	Arlington VA	22202-4704
NAVINGEN	1254 Ninth St SE	Washington Navy Yard DC	20374-5006
USA/IG	1700 Army Pentagon	Washington DC	20310-1700
SAF/IG	1140 Air Force Pentagon	Washington DC	20330-1140
AFIA/CC/CV	9700 G Avenue SE	Kirtland AFB NM	87117-5670

ADDRESSEE: (Report any changes or corrections to)

HQ AFIA/FOI
9700 G Avenue
Kirtland AFB NM 87117-5670
COMM 505-846-2073
DSN 246-2073
FAX (COMM) 505-846-1904
DSN: 246-1904

SECTION IV – APPENDICIES

APPENDIX A – Joint Commission on Accreditation of Healthcare Organizations Quality Report – Gulfport Campus



Welcome to the Joint Commission's Quality Report. We know how important reliable information is to you and your family when making health care decisions. This Quality Report will help you make the right decisions to meet your needs. Since 1951, Joint Commission has been the national leader in setting standards for health care organizations. When a health care organization seeks accreditation, it demonstrates commitment to giving safe, high quality health care and to continually working to improve that care.

The Quality Report is only one way to determine whether a health care organization can meet your needs. Discuss this report with your doctor or with other professional acquaintances before making a care decision. In addition to the accreditation status of the organization, the Quality Report uses checks, pluses, and minuses in the key area of National Patient Safety Goals - safety guidelines that target the prevention of medical errors such as surgery on the wrong side of the body and safe medication use.

Not all measures are relevant to or available for all types of health care organizations. The Joint Commission will add relevant measures of health care quality as more measures become available. Your comments are just as important to us. The content and format of the Quality Report will be updated from time to time based on changes in the health care industry and your suggestions. Please call Customer Service at 630-792-5800 or e-mail the Joint Commission at qualityreport@jcaho.org with your comments and suggestions.

Dennis S. O'Leary, MD
President of the Joint Commission

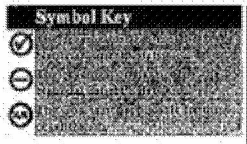
Armed Forces Retirement Home-Gulfport

1800 Beach Drive, Gulfport, MS Org ID: 375



Summary of Quality Information

Symbol Key



For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Accreditation Decision
Accredited

Decision Effective Date
March 24, 2005

Accredited Programs	Last Full Survey Date
Ambulatory Care	March 23, 2005
Assisted Living	March 23, 2005
Long Term Care	March 23, 2005

	Compared to other Joint Commission Accredited Organizations	
	Nationwide	Statewide
2005 National Patient Safety Goals:	✓	N/A *

* State Results are not Calculated for the National Patient Safety Goals.

Armed Forces Retirement Home-Gulfport

1800 Beach Drive, Gulfport, MS Org ID: 375



Locations of Care

* Primary Location

Locations of Care	Available Services	
Armed Forces Retirement Home-Gulfport * 1800 Beach Drive Gulfport, MS 39507-1597	• Dentistry • Diagnostic Tests • Internal Medicine	• Nursing Home • Podiatry • Rehabilitation and Physical Medicine

Armed Forces Retirement Home-Gulfport



2005 National Patient Safety Goals

Symbol Key

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Ambulatory Care

Safety Goals	Organizations Should	Implemented
Identify Patients Correctly	Use at least two (2) ways to identify a patient when performing procedures, taking blood or giving medicines or blood products. The patient's room number cannot be used to identify the patient.	✓
Improve Effective Communication	Assure a staff member who receives an order over the phone or verbally, will "read back" the order to the person who gave the order.	✓
	Create a list of acceptable standardized abbreviations and a "Do Not Use" list to help reduce the risk of errors. Medical abbreviations can lead to errors.	✓
	Improve the time it takes to get test results to the appropriate caregiver.	✓
Improve the Safety of High-Alert Medications	Remove high-alert medications from patient care units. Medications that have the highest risk of causing injury when misused are called "High-Alert" Medications.	✓
	Standardize and limit the number of drug concentrations.	✓
	Create a list of medicines that have names that either look alike or sound alike and use the list to prevent errors involving those medicines.	✓
Improve Infusion Pump Safety	Assure pumps used to give fluids or medicine into a vein are set so that the fluid cannot be given too quickly. An infusion pump releases an amount of medicine in a specific period of time.	✓
Reduce Health Care Acquired Infections	Follow current Centers for Disease Control (CDC) handwashing guidelines.	✓
	Manage as sentinel events all cases of health care-acquired infections. A sentinel event is any unanticipated death or major permanent loss of function.	✓
Ensure medicines aren't accidentally stopped.	When admitting a patient, create a list, with the patient's assistance, of the medicines that the patient takes. The list should be updated with new medicines prescribed in the facility. [To be fully implemented by January 2006.]	✓
	The complete list of a patient's medicines is passed on to new caregivers—even if the caregiver is outside of the facility.	✓
Reduce the risk of fires during surgery.	Surgical staff members know how to control heat and fuels, like oxygen and gas, in the operating room. Also, there are guidelines to follow to prevent oxygen from being trapped under sheets and other materials that can catch fire.	✓
Universal Protocol	"Beginning July 1, 2004, the Universal Protocol for preventing wrong site, wrong procedure, and wrong person surgery became effective. The Universal Protocol replaced the requirements identified above.	✓

5

Armed Forces Retirement Home-Gulfport



2005 National Patient Safety Goals

Symbol Key

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Assisted Living

Safety Goals	Organizations Should	Implemented
Identify Residents Correctly	Use at least two (2) ways to identify a resident when performing procedures, taking blood or giving medicines or blood products. The resident's room number cannot be used to identify the resident.	✓
	Use a "time-out" just before starting the procedure to allow the entire surgical team to ensure the correct resident, procedure and body part.	✓
Improve Effective Communication	Assure a staff member who receives an order over the phone or verbally, will "read back" the order to the person who gave the order.	✓
	Create a list of acceptable standardized abbreviations and a "Do Not Use" list to help reduce the risk of errors. Medical abbreviations can lead to errors.	✓
Improve Infusion Pump Safety	Assure pumps used to give fluids or medicine into a vein are set so that the fluid cannot be given too quickly. An infusion pump releases an amount of medicine in a specific period of time.	✓
Reduce Health Care Acquired Infections	Follow current Centers for Disease Control (CDC) handwashing guidelines.	✓
	Manage as sentinel events all cases of health care-acquired infections. A sentinel event is any unanticipated death or major permanent loss of function.	✓
Ensure medicines aren't accidentally stopped	When admitting a resident, create a list, with the resident's assistance, of the medicines that the resident takes. The list should be updated with new medicines prescribed in the facility. [To be fully implemented by January 2006.]	✓
	The complete list of a resident's medicines is passed on to new caregivers—even if the caregiver is outside of the facility.	✓
Reduce the risk of residents hurting themselves by falling	Check each resident for the risk of falling, including any medicines the resident is taking that might make the resident weak, dizzy, or sleepy. If there is a risk of the resident falling, take appropriate precautions.	✓
Reduce the risk of the flu and pneumonia in older adults	Flu vaccine is given to residents and noted in the resident's medical record.	✓
	Pneumonia vaccine is given to residents and noted in the resident's medical record.	✓
	New cases of the flu are tracked in order to control a possible outbreak.	✓



2005 National Patient Safety Goals

Symbol Key

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Long Term Care

Safety Goals	Organizations Should	Implemented
Identify Patients Correctly	Use at least two (2) ways to identify a patient when performing procedures, taking blood or giving medicines or blood products. The patient's room number cannot be used to identify the patient.	✓
	Use a "time-out" just before starting the procedure to allow the entire surgical team to ensure the correct patient, procedure and body part.	✓
Improve Effective Communication	Assure a staff member who receives an order over the phone or verbally, will "read back" the order to the person who gave the order.	✓
	Create a list of acceptable standardized abbreviations and a "Do Not Use" list to help reduce the risk of errors. Medical abbreviations can lead to errors.	✓
Improve the Safety of High-Alert Medications	Remove high-alert medications from patient care units. Medications that have the highest risk of causing injury when misused are called "High-Alert" Medications.	✓
	Standardize and limit the number of drug concentrations.	✓
	Create a list of medicines that have names that either look alike or sound alike and use the list to prevent errors involving those medicines.	✓
Improve Infusion Pump Safety	Assure pumps used to give fluids or medicine into a vein are set so that the fluid cannot be given too quickly. An infusion pump releases an amount of medicine in a specific period of time.	✓
Reduce Health Care Acquired Infections	Follow current Centers for Disease Control (CDC) handwashing guidelines.	✓
	Manage as sentinel events all cases of health care-acquired infections. A sentinel event is any unanticipated death or major permanent loss of function.	✓
Ensure medicines aren't accidentally stopped.	When admitting a resident, create a list, with the resident's assistance, of the medicines that the resident takes. The list should be updated with new medicines prescribed in the facility. [To be fully implemented by January 2006.]	✓
	The complete list of a resident's medicines is passed on to new caregivers—even if the caregiver is outside of the facility.	✓
Reduce the risk of residents hurting themselves by falling.	Check each resident for the risk of falling, including any medicines the resident is taking that might make the resident weak, dizzy, or sleepy. If there is a risk of the resident falling, take appropriate precautions.	✓
	Make improvements in the facility and procedures to reduce the number of resident falls, including guidelines for moving residents, such as from a bed to a wheelchair.	✓
Reduce the risk of the flu and pneumonia in older adults.	Flu vaccine is given to patients and noted in the resident's medical record.	✓
	Pneumonia vaccine is given to residents and noted in the resident's medical record.	✓
	New cases of the flu are tracked in order to control a possible outbreak.	✓

Armed Forces Retirement Home-Gulfport



Organizations Quality Report History

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

2005	Accredited	March 24, 2005
	Active Programs: Ambulatory Care Assisted Living Long Term Care	
2002	Accredited	August 01, 2002
	Accreditation with Requirements for Improvement	February 26, 2002
	Active Programs: Ambulatory Care Assisted Living Long Term Care	
1999	Accreditation with Requirements for Improvement	March 04, 1999
	Active Programs: Ambulatory Care Long Term Care	
1996	Accredited	January 10, 1997
	Accreditation with Requirements for Improvement	February 14, 1996
	Active Programs: Ambulatory Care Long Term Care	

APPENDIX B – Joint Commission on Accreditation of Healthcare Organizations Quality Report – Washington DC Campus

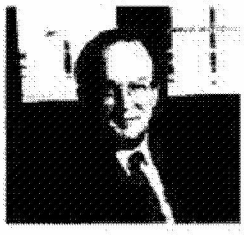
Armed Forces Retirement Home-WASHINGTON

Quality Report

Joint Commission
on Accreditation of Healthcare Organizations

Version: 3
Date: 1/31/2006

Armed Forces Retirement Home-WASHINGTON



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The Quality Report is only one way to determine whether a health care organization can meet your needs. Discuss this report with your doctor or with other professional acquaintances before making a care decision. In addition to the accreditation status of the organization, the Quality Report uses checks, pluses, and minuses in the key area of National Patient Safety Goals - safety guidelines that target the prevention of medical errors such as surgery on the wrong side of the body and safe medication use.

Not all measures are relevant to or available for all types of health care organizations. The Joint Commission will add relevant measures of health care quality as more measures become available. Your comments are just as important to us. The content and format of the Quality Report will be updated from time to time based on changes in the health care industry and your suggestions. Please call Customer Service at 630-792-5800 or e-mail the Joint Commission at qualityreport@jcaho.org with your comments and suggestions.

Dennis S. O'Leary, MD
President of the Joint Commission

Armed Forces Retirement Home-WASHINGTON



Summary of Quality Information

Symbol Key

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Accreditation Decision
Accredited

Decision Effective Date
October 15, 2005

Accredited Programs	Last Full Survey Date
Ambulatory Care	October 14, 2005
Long Term Care	October 14, 2005

	Compared to other Joint Commission Accredited Organizations	
	Nationwide	Statewide
2005 National Patient Safety Goals:	✓	N/A *

* State Results are not Calculated for the National Patient Safety Goals.



Locations of Care

* Primary Location

Locations of Care	Available Services	
Armed Forces Retirement Home-W, SCOTT Building 3700 North Capital Street, NW Washington, DC 20011-8400	• Dentistry • Internal Medicine • Ophthalmology-Optometry • Podiatry • Urology	
Armed Forces Retirement Home-Washington * 3700 North Capital Street, N.W. Washington, DC 20011-8400	• Dentistry • Internal Medicine • Nursing Home	• Ophthalmology-Optometry • Podiatry • Urology



2005 National Patient Safety Goals

Symbol Key

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Ambulatory Care

Safety Goals	Organizations Should	Implemented
Identify Patients Correctly	Use at least two (2) ways to identify a patient when performing procedures, taking blood or giving medicines or blood products. The patient's room number cannot be used to identify the patient.	✓
Improve Effective Communication	Assure a staff member who receives an order over the phone or verbally, will "read back" the order to the person who gave the order.	✓
	Create a list of acceptable standardized abbreviations and a "Do Not Use" list to help reduce the risk of errors. Medical abbreviations can lead to errors.	✓
	Improve the time it takes to get test results to the appropriate caregiver.	✓
Improve the Safety of High-Alert Medications	Remove high-alert medications from patient care units. Medications that have the highest risk of causing injury when misused are called "High-Alert" Medications.	✓
	Standardize and limit the number of drug concentrations.	✓
	Create a list of medicines that have names that either look alike or sound alike and use the list to prevent errors involving those medicines.	✓
Improve Infusion Pump Safety	Assure pumps used to give fluids or medicine into a vein are set so that the fluid cannot be given too quickly. An infusion pump releases an amount of medicine in a specific period of time.	✓
Reduce Health Care Acquired Infections	Follow current Centers for Disease Control (CDC) handwashing guidelines.	✓
	Manage as sentinel events all cases of health care-acquired infections. A sentinel event is any unanticipated death or major permanent loss of function.	✓
Ensure medicines aren't accidentally stopped.	When admitting a patient, create a list, with the patient's assistance, of the medicines that the patient takes. The list should be updated with new medicines prescribed in the facility. [To be fully implemented by January 2006.]	✓
	The complete list of a patient's medicines is passed on to new caregivers—even if the caregiver is outside of the facility.	✓
Reduce the risk of fires during surgery.	Surgical staff members know how to control heat and fuels, like oxygen and gas, in the operating room. Also, there are guidelines to follow to prevent oxygen from being trapped under sheets and other materials that can catch fire.	✓
Universal Protocol	"Beginning July 1, 2004, the Universal Protocol for preventing wrong site, wrong procedure, and wrong person surgery became effective. The Universal Protocol replaced the requirements identified above.	✓



2005 National Patient Safety Goals

Symbol Key

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Long Term Care

Safety Goals	Organizations Should	Implemented
Identify Patients Correctly	Use at least two (2) ways to identify a patient when performing procedures, taking blood or giving medicines or blood products. The patient's room number cannot be used to identify the patient.	✓
	Use a "time-out" just before starting the procedure to allow the entire surgical team to ensure the correct patient, procedure and body part.	✓
Improve Effective Communication	Assure a staff member who receives an order over the phone or verbally, will "read back" the order to the person who gave the order.	✓
	Create a list of acceptable standardized abbreviations and a "Do Not Use" list to help reduce the risk of errors. Medical abbreviations can lead to errors.	✓
Improve the Safety of High-Alert Medications	Remove high-alert medications from patient care units. Medications that have the highest risk of causing injury when misused are called "High-Alert" Medications.	✓
	Standardize and limit the number of drug concentrations.	✓
	Create a list of medicines that have names that either look alike or sound alike and use the list to prevent errors involving those medicines.	✓
Improve Infusion Pump Safety	Assure pumps used to give fluids or medicine into a vein are set so that the fluid cannot be given too quickly. An infusion pump releases an amount of medicine in a specific period of time.	✓
Reduce Health Care Acquired Infections	Follow current Centers for Disease Control (CDC) handwashing guidelines.	✓
	Manage as sentinel events all cases of health care-acquired infections. A sentinel event is any unanticipated death or major permanent loss of function.	✓
Ensure medicines aren't accidentally stopped.	When admitting a resident, create a list, with the resident's assistance, of the medicines that the resident takes. The list should be updated with new medicines prescribed in the facility. [To be fully implemented by January 2006.]	✓
	The complete list of a resident's medicines is passed on to new caregivers—even if the caregiver is outside of the facility.	✓
Reduce the risk of residents hurting themselves by falling.	Check each resident for the risk of falling, including any medicines the resident is taking that might make the resident weak, dizzy, or sleepy. If there is a risk of the resident falling, take appropriate precautions.	✓
	Make improvements in the facility and procedures to reduce the number of resident falls, including guidelines for moving residents, such as from a bed to a wheelchair.	✓
Reduce the risk of the flu and pneumonia in older adults.	Flu vaccine is given to patients and noted in the resident's medical record.	✓
	Pneumonia vaccine is given to residents and noted in the resident's medical record.	✓
	New cases of the flu are tracked in order to control a possible outbreak.	✓



Organization Commentary on the Quality Report

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Commentary

REFERENCE
LOCATIONS OF CARE section of the QUALITY REPORT.

Since December 28, 2002 the name was changed to:
Benjamin King Health Center,
ARMED FORCES RETIREMENT HOME-WASHINGTON
3700 North Capitol Street, N.W.
Washington, DC <he />
The Post Office recently changed the ZIP CODE to:
20011-8400.

July 6, 2005 ADDENDUM--
OUTSTANDING PERFORMANCE AWARD ISSUED BY THE U.S. DEPARTMENT OF LABOR
received for achieving a greater than 10% reduction in both total and lost time case rates for FY 2004 issued by the U.S. Department of Labor, Occupational Safety and Health Administration, Washington, D.C. 20210. The award certificate is on file in the offices of the Armed Forces Retirement Home Designated Agency Safety and Health Official.

The award certificate is signed by both the--
Acting Assistant Secretary of Labor, OSHA (Jonathan L. Snare)
and the Director of OWCP (Shelby Hallmark.)

Prepared By:

Health Care Organization ID#:	4275
Organization Name:	Armed Forces Retirement Home-WASHINGTON
Address:	3700 North Capitol Street, NW Washington, DC 20011-8400
Chief Executive Officer:	Dr. Linda Rader
Phone Number:	(202)730-3323
Date:	07/08/2005



Organizations Quality Report History

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

2005	Accredited	October 15, 2005
	Accredited	July 01, 2005
	Active Programs: Ambulatory Care, Long Term Care	
2002	Accredited	January 28, 2004
	Accreditation with Requirements for Improvement	July 16, 2003
	Accredited	June 20, 2003
	Accreditation with Requirements for Improvement	October 25, 2002
	Active Programs: Long Term Care	
1999	Accredited with Commendation	October 01, 1999
	Active Programs: Long Term Care	
1996	Accredited with Commendation	October 31, 1996
	Active Programs: Long Term Care	

APPENDIX C – Finding Cause Codes

For tracking purposes, all findings were assigned a cause code in the inspection report. Only the primary contributing cause code was identified and assigned against the finding. The cause codes are listed as follows:

Oversight: Errors in leadership or supervision at any level.

Experience: Errors committed despite adequate training, oversight, and guidance.

Guidance: Inadequate, confusing, or specific written direction that is contrary or prevents adequate accomplishment of the task.

Training: Individuals inadequately trained/prepared to accomplish the task.

Equipment: Support equipment unavailable, inadequate, or inoperable due to circumstances beyond the Agency's control.

Manpower: Personnel resources not available to accomplish task or mission needs.

Safety: Operations not conducted in a safe and efficient manner.

Security: Resources not properly protected in relation to the threat.

Other: Isolated events involving deficient actions of individuals not attributable to any of the previous causes.

APPENDIX D – Department Of Defense, Assistant Inspector General for Inspections and Evaluations, Reply to Report Findings and Recommendations

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202-4704

MAR 13 2006

MEMORANDUM FOR THE INSPECTOR GENERAL, DEPARTMENT OF THE AIR FORCE

SUBJECT: Armed Forces Retirement Home (AFRH) 2005 Triennial Inspection Draft Report

We have reviewed the subject draft report and concur with Recommendation AR-01 that the AFRH establish a Memorandum of Agreement with the Inspector General of the Department of Defense, to provide services to AFRH in accordance with section 411(f), title 24, United States Code. The draft report contains no other recommendations to the Inspector General of DoD.

We appreciate the opportunity to comment. Our point of contact for this action is Ms. Madelaine Fusfield at (703) 604-9134 (DSN 664-9134) Madelaine.Fusfield@dodig.mil, or Ms. Beverly Cornish at (703) 604-9127 (DSN 664-9127) Beverly.Cornish@dodig.mil.

Wm Breit Morrison, III
Assistant Inspector General
for Inspections and Evaluations

APPENDIX E – Deputy Under Secretary of Defense, Military Community and Family Policy, Reply to Report Findings and Recommendations

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

MAR 23 2006

PERSONNEL AND READINESS

MEMORANDUM FOR DIRECTOR AIR FORCE INSPECTION AGENCY, OFFICE OF THE INSPECTOR GENERAL

SUBJECT: Armed Forces Retirement Home (AFRH) 2005 Triennial Inspection Draft Report – Release for Comment

In response to your request for comment on the subject draft inspection report, I have attached AFRH's comments, which I understand will be included as an appendix to the final report. The Department will review these comments and monitor the findings until all required actions are completed. The Air Force Inspection Agency (AFIA) conducted a very comprehensive review of AFRH's administrative and management functions to ensure compliance with statute, and relied on recent Joint Commission on Accreditation of Healthcare Organizations to assess medical services. As you note, this construct was a departure from previous triennial inspections but one that will be a positive learning process for all. The thorough checklist that your team developed will provide an excellent baseline to further standardize future inspections and expectations.

I believe it also important to capture the major positive achievements that have been made during the 3-years since the last triennial inspection, i.e., the sale of real estate at both campus that added $22.5 million to the Trust Fund; the successful year-long conversion of the AFRH pay function to the National Finance Center in New Orleans; the development of the long range Master Plan for the Washington campus; the completion of a Phase 1 effort that eliminated 93 obsolete policy issuances and progress towards achieving Phase 2 goals. In Phase 2, AFRH has drafted 54 Agency level policy documents, which are in final coordination, and which will ultimately cancel an additional 61 outdated instructions. While the inspection team noted discrepancies related to lack of policy guidance, extensive effort has gone into this effort and these policies will be finalized this year.

AFRH management has made significant strides in developing and adhering to their "One Model" plan and aligning the mission/vision of the Home to the Agency's strategic plan, detailed business plans, individual personnel performance plans, and ultimately reporting the results in the Agency's Performance Accountability Report. AFRH also moved to a Joint Financial Management Improvement Plan, a compliant financial management system, which integrated procurement, investments, payroll, accounting, travel, and credit cards.

I am particularly pleased that AFIA was able to document that with the implementation of several cost cutting measures, revenues exceeded operating expense by approximately $6 million in fiscal year 2005, reversing a decade long trend of declining Trust Fund revenues from operations. These savings were achieved without negatively impacting the quality of resident services and the AFRH received an unqualified audit opinion for fiscal year 2005.

Overall, I am pleased with the findings that AFRH provides quality care and effective management. But we can always improve and will address the issues raised in this report.

Finally, I would like to specifically thank Colonel Tom Stark, USAF, Inspection Team Chief and Lt Col Steve Sample, USAF, Deputy Team Chief, for their professional dedication to assuring a quality product. They provided excellent leadership throughout the process; in the conduct of the inspection, and assistance to my staff and AFRH personnel during all pre- and post- inspection requirements. Thank you to the AFIA Team for a job well done.

Sincerely,

for Jane Burke

Leslye A. Arsht
Deputy Under Secretary of Defense
(Military Community and Family Policy)

Attachment:
As stated

APPENDIX F – Chief Operating Officer, Armed Forces Retirement Home, Reply to Report Findings and Recommendations

Armed Forces Retirement Home
Chief Operating Officer
3700 N. Capitol Street, Box 1303
Washington, DC 20011-8400

March 21, 2006

Ms. Leslye A. Arsht
Deputy Under Secretary of Defense
Military Community and Family Policy
4000 Pentagon (Room 5A734)
Washington DC 20301

Dear Ms. Arsht:

The Armed Forces Retirement Home (AFRH) sincerely appreciates the opportunity to review the draft Air Force Triennial Inspection Report and to provide comments on the findings identified. Findings contained in the draft report were provided to AFRH senior managers who either provided additional clarification regarding findings or in some cases provided progress updates. We offer our comments as constructive feedback with a focus on further strengthening the inspection report.

As a result of Hurricane Katrina, some of the Gulfport findings identified by the inspection team now seem to be in the "overtaken by events" category. We have consolidated several of the management findings if they applied to both campuses in Attachment A. Attachment B lists AFRH-Gulfport findings that we will not provide comment.

I am available to discuss the attached comments, concerns, and recommendations with you and the Air Force Inspection Agency at your convenience. My point of contact for this inspection is Ms. Nancy Duran, the AFRH Inspector General who can be reached at (202) 730-3077.

Again, thank you for the opportunity to comment.

Sincerely,

TIMOTHY C. COX
Chief Operating Officer

Attachments
(As stated)

COMMENTS ON AIR FORCE TRIENNIAL REVIEW OF THE ARMED FORCES RETIREMENT HOME - DRAFT REPORT -

1. FINDING A-01: Armed Forces Retirement Home (AFRH)-Washington operated without a Director.

Comment: Mr. Benjamin Laub was hired as the Director of AFRH-Washington on September 26, 2005.

2. FINDING A-02: Some rules for operation of AFRH were not current and lacked standardization.

Comment: The AFRH continues to staff new policy that resulted from the zero-base review initiative. Formerly seven generations of policy existed before the review process started. The majority of the remaining policy documents will be issued in the third and fourth quarter of FY06.

3. FINDING A-03/A-04: AFRH did not use a Local Board of Trustees.

Comment: While legislation mandates that the AFRH utilize Local Boards in an advisory capacity at each home, there is concern that these Boards, as structured, do not meet the current issues facing AFRH. For example, the AFRH needs experts in areas such as TRICARE, MEDICARE, issues concerning aging similar to those being addressed by the Federal Administration on Aging. As we proceed on construction projects which will house our aged population, we need experts in designing healthcare facilities that take into account the needs and desires of seniors. We also need individual(s) who know how to effectively communicate our issues to those who can influence law makers, etc. The current Local Board lacks this vitality. In some case, certain Local Board members actually resisted change and held on to antiquated strategies that failed to achieve results and actually paralyzed progress. Governing legislation also states that the AFRH's Chief Operating Officer has the authority to "establish any advisory body or bodies that the Chief Operating Officer considers to be necessary." The AFRH is in the process of developing a network of potential Board members who will respond to issues on an as-needed basis. In the past, Board meetings/membership took on a life of its own, became an administrative nightmare and actually became too cumbersome to achieve needed results. Pulling these talents that will assist the AFRH in achieving a new level of excellence. AFRH will also address legislative changes that may be required as a result of updating our Boards structure.

4. FINDING C-01: AFRH did not establish a system of priorities for the acceptance of residents.

Comment: While the AFRH did have a system of priorities, it was not codified in a formal policy document. The system of priorities was really an allocation, by percentage, across the four eligibility categories. In 2015 the percentages would be reallocated across three categories because the fourth category that made women who served prior to 1948 eligible would likely see a decline in applicants. The AFRH will revisit this plan by the end of this fiscal year and explore options that are not necessarily percentage based.

5. FINDING C-02: AFRH did not establish prescribed rules to equitably determine eligibility standards for the acceptance of residents.

Comment: The AFRH will revisit this plan by the end of this fiscal year and explore options.

6. FINDING D-01: The September 30, 2004 AFRH Trust Fund balance was not accurately portrayed in the FY 06 Presidential Budget Submission.

Comment: The AFRH and its accounting team from the Bureau of Public Debt worked with the Office of Management and Budget and the MAX budget submission was corrected.

7. FINDING D-02: AFRH did not file audited financial statements for FY 03 and FY 04.

Comment: An audit was conducted in FY05; the AFRH received an "unqualified opinion." The audited financial statement was included in the Agency's Performance and Accountability Report for FY 05.

8. FINDING D-03: AFRH did not establish effective oversight of financial transaction processing.

Comment: The Bureau of Public Debt has reversed $157,644 from current revenue and recorded a prior period adjustment in accordance with the Statement of Federal Financial Accounting Standards No. 7. The AFRH is in the process of developing new procedures to ensure all deposits are received and recorded properly by BPD.

9. FINDING D-04: AFRH did not complete an annual Statement of Assurance.

Comment: The annual Statement of Assurance was included in the Agency's FY 05 Performance and Accountability Report that was submitted to OMB.

10. FINDING D-05: AFRH did not establish a long term Financial Plan.

Comment: AFRH is working with OMB and will submit a five-year financial management plan in FY06 that will establish milestones for equipment acquisition and other actions necessary to implement a plan consistent with requirements.

11. FINDING D-06: AFRH did not establish an effective accounting mechanism for the Resident Fund.

Comment: AFRH is developing a formal agreement with the Navy Morale, Welfare and Recreation (MWR) accounting office at Millington, Tennessee to include duties to be performed. AFRH and BPD believe that the Air Force IG Draft Report shows several areas where improvements have been made and are in the process of being made. We affirm that the findings will strengthen our already steadfast diligence in adhering to proper procurement practices and improving our processes.

12. FINDING D-07/D-08/D-09: AFRH lacked adequate oversight of the Government Purchase Card program.

Comment: The AFRH is working with BPD to develop policy. An Agency level Program Manager has been designated and is being trained to provide oversight of AFRH's credit card program.

15. FINDING E-01: AFRH's Records Management program did not meet minimum DoD requirements.

Comment: While the AFRH needs to meet minimum standards, the AFRH does not necessarily follow DoD guidelines. In 2004, the AFRH contacted the National Archives and Records Administration (NARA) and solicit their help in developing an up-to-date records schedule for AFRH Agency files. Due to the unique nature of the files in AFRH's possession, a senior NARA specialist came on-site and inventoried our files and personally developed a records retention/disposition schedule. This process spanned approximately 9 months. While the AFRH was awaiting approval of the draft records schedule by NARA, the AFRH Records Manager drafted AFRH Agency Directive 1-6 which updates the Agency's Records Management Program and assigns responsibilities. The new Directive will promulgate the NARA developed AFRH Records Schedule. AFRH Agency Directive1-6 is in the final coordination stage.

16. FINDING E-02/E-05: AFRH–Gulfport's/Washington's Records Management program did not meet minimum DoD requirements.

Comment: While the AFRH needs to meet minimum standards, the Agency does not necessarily follow DoD guidelines. AFRH has taken steps in hiring and reviewing its current disposition chart and hired an Administrative Officer on August 26, 2006 with prior records management experience. The Administrative Officer met with personnel familiar with the current records/storage needs. A meeting was scheduled in January 2006 with a representative of the National Archives and Records Administration to coordinate the dissemination of Records. The following action plan was established: (l) Directive/approval to include Records Management training requirements for all staff. and appointment of 6 liaisons to serve as

administrators of the records management initiative. (2) Federal Records Center or Private files will be sent in 5 year blocks; full storage 15/20 years. (3) Review of files to be moved or destroyed. (4) Training of Staff. (6) Inventory of office files. (7) Creation of new file plans. (8) Creation of standard Records Management manual. (9) Match IT with Records Management requirements. (10) Transfer permanent records, photos, museum documents, CD, ledgers.

17. FINDING E-04/E-06: AFRH Freedom of Information Act program did not meet minimum public law requirements.

Comment: AFRH hired an additional FOIA liaison with FOIA experience. Training is planned May 2006, the earliest scheduled class.

18. FINDING F-01/F-03/F-04: AFRH-Washington did not establish a software license management program to ensure compliance with Executive Order 13103 requirements

Comment: During the Air Force Inspection Agency assessment, AFRH was working on several projects to address the identified security and infrastructure findings. Below are the solutions that are completed or in process that address the IG's IT findings.

Comment: AFRH has signed a Memorandum of Agreement with the Office of Information Technology, Franchise Security Services of the Bureau of Public Debt, U.S. Treasury (BPD) to establish a Security Program, Information Security Training Program, and certify and accredit our network infrastructure. Within the tasks of these programs, the deficiencies outlined in the IG review, with AFRH's documentation, policies, and user security training, will be resolved. The project began in early March 2006 and will conclude in August 2006.

AFRH has purchased Novel 6.5 and Zenworks 7 to upgrade and install on their existing Novell on March 20, 2006. This upgrade will allow AFRH's IT staff to implement desktop management tools, patch management, remote management functions, and application software and asset inventory. These tools will allow for specific policies based on a use/group's business roles, roaming profiles that will eliminate the need of shared accounts and access to local passwords or accounts, and distribution of applications and software updates for the system which will eliminate the security issues on the local desktop. This software upgrade and enhancement will give IT the ability to stay "on-top" of the constant Microsoft updates that are required to meet DoD's security policies. Zenworks' software and asset inventory module will resolve the issue of unauthorized software and software accountability for licensing regulations.

The IG also identified an issue with Windows 98 system residing on AFRH's network. AFRH has deployed new Dell systems running Windows XP to replace all of the Microsoft Windows 99 systems. This replacement has eliminated the security issues associated with Windows 98. This project was completed in February 2006.

AFRH's IT completed the network upgrade in December 2005. This upgrade deployed a DS3 internet connection, internal and external firewall, segmented network zones, and a DMZ zone. This infrastructure has eliminated the security issues on an enterprise level while the combination of Zenworks and Norton Antivirus will eliminate desktop security and usage issues. The firewall has been designed to allow only specifics ports to communicate within the network based on the zones, employees, residents, and Rental Agency's profiles. AFRH manages the firewall and its associated ports and have the ability to manage the intrusion detections and URL filtering processes.

The internal bottleneck with the network will be addressed with the switch upgrade. This upgrade will eliminate the network bottlenecks while also preparing the Agency for VoIP (Voice over IP) deployment. (a network diagram has been completed that details the zones and their security parameters. The external network has been documented and the diagram will be included in the documentation that BPD will complete. The switch replacement project is expected to be completed by November 2006.

AFRH will utilize the computer training room to conduct new employee training and refresher courses for security, desktop usage, and Agency policies. Once BPD has completed the documentation sections and prepared the training program, a training schedule will be disseminated to all AFRH employees. Once the employees have completed the training, they will be required to sign a sheet verifying their participation in the training which will be added to the security documentation. This project coincides with the project identified in Finding 1, above, and will be completed during that timeframe.

23. <u>FINDING G-01:</u> AFRH, working with BPD, did not establish an overall acquisition strategic plan to ensure use of a systematic and disciplined approach to achieve effective AFRH acquisition.

Comment: AFRH and BPD are working closely to identify all requirements and make determinations on the best overall strategy for those requirements. The AFRH Director, Service Chiefs and BPD Contract Team have a conference call every other week to discuss current acquisitions and upcoming needs to ensure that needs are planned for and met.

BPD is currently reviewing all service orders/contracts that are scheduled to expire on September 30, 2006, to determine what actions should be combined and to determine the appropriate solicitation method (schedule, set-aside, contract type, etc.). This review will serve as a basis for determining which actions can be converted to performance-based and where QASPs are needed.

As appropriate, several AFRH requirements that were fulfilled by other government agencies are being transitioned to BPD as the current agreements expire. Each requirement will be reviewed to determine what the appropriate strategy is. Although there will always be reliance on identification provided by Administrative Resource Center (ARC) customers, ARC listens closely to all conversations to determine what if any effect it will have on the customers'

acquisition needs. When potential needs are identified, they are discussed with the customer.

24. FINDING G-02: AFRH, working with BPD, did not establish an acquisition strategy for individual contracts.

Comment: At the time the reviewed contracts were solicited, BPD did not complete individual acquisition plans for commercial item acquisitions. We later determined that we should have. This process has been changed. In accordance with FAR 7.105 and DTAR 1007.103(d), the contract Specialist and Contracting Officer work with the appropriate technical personnel to develop acquisition plans for each action above the simplified acquisition level. The plans are reviewed by the Performance Based Contracting Advocate and the Contracting Officer.

25 FINDING G-03: AFRH, working with the BPD, did not establish and use quality assurance surveillance plans (QASP) for service contracts. Also they were not performing contract quality assurance actions.

Comment: AFRH and BPD are working on this issue. In accordance with 37.602-2 and 46.104, we have incorporated QASPs in all new service contracts. As mentioned above, we are in the process of reviewing all requirements that will expire at the end of the fiscal year and will be drafting QASPs that are commensurate with size and complexity of the service acquisition. During the market research phase, we obtained samples of performance work statements and QASPs that are utilized to develop the new acquisitions. Samples are obtained from a variety of sources including FedBiz Ops, other agencies, and websites such as Defense Acquisition University.

24. FINDING G-04: AFRH, working with the BPD, did not accomplish annual contractor performance evaluations using Contractor Performance System (CPS).

Comment: Due to the lack of documentation in the contract files and history with the contracts that were transferred to BPD, BPD made a decision to begin the evaluations during the Fall of 2005. This would allow BPD and AFRH to document performance of the contractors and address issues (if necessary) with the Contractors prior to issuing a formal evaluation that may or may not be accurate.

BPD provided training to each of the COTRs on how to use the Contractor Performance System (CPS) to document contractor's performance evaluations in December 2005. All contracts have been evaluated and most of the evaluations have been finalized.

At option renewal or close of a contract exceeding $100,000, BPD will contact the COTR to initiate the performance evaluation. BPD will provide assistance to any COTR who needs it. BPD will monitor the entire process to make sure that all evaluations have been completed in a timely manner.

25. FINDING G-05: AFRH, working with BPD, did not use the appropriate clauses on contracts that contained requirements for government furnished property (GFP), government furnished material (GFM) and/or government furnished facilities in the Statement of Work (SOW) and Performance Work Statement (PWS)

Comment: We have reviewed each contract to determine whether there is GFP, GFM, or GFF and if the appropriate clauses are included. We are now working on ensuring that we have a complete and accurate listing of all GFP, GFM, and GFF for each contract. In accordance with FAR 45, we will either incorporate or update the listing of GFP, GFM, or GFF and make any necessary changes to the clauses via modification to the contract. We anticipate that these actions will be completed by June 2006.

As BPD and AFRH COTRs plan each acquisition, we are obtaining this information so that the appropriate clauses and listings will be incorporated into the solicitation and resulting award.

BPD will ensure that the GFP, GFM, and GFF are inventoried each year at option renewal or at the end of contract performance

26. FINDING G-06: AFRH, working with the BPD, did not ensure consistent Contracting Officer Technical Representative (COTR) policy and guidance.

Comment: AFRH and BPD are working together to ensure that all COTR policy and guidance are consistent. The documents will be revised by the end of FY 06. The training requirements were changing during the time the draft Agency Notice was being developed and the previous training requirements were used. The training requirements will be updated to reflect 24 hours of a basic acquisition course and 8 hours of maintenance training each year.

BPD developed and provided the refresher training last year on the overall acquisition process and record keeping. This year the refresher training is scheduled for the week of April 17 and will focus on the financial aspect of acquisitions. The yearly refresher training will be based on the area that needs the most attention. Additional training sessions will be developed and delivered as necessary.

27. FINDING G-07: AFRH did not properly fund firm fixed price contracts.

Comment: In FY 06, AFRH did fully fund the firm-fixed price contract in accordance with FAR 32.703.1.

28. FINDING H-01: AFRH-Washington did not develop strategies for maintaining cultural resources (historic buildings) and the method of compliance.

Comment: The Agency had produced a Phase I environmental cultural resource study and an inventory of assets documenting their historic significance as recognized and

acknowledged by the inspection team. As a follow on strategy for restoring and maintaining these cultural resources, the Agency (l) seeks independent funding from historic preservation partners as we have accomplished to date in the exterior restoration of the Lincoln cottage and planning is underway to restore/rehabilitate the interiors of the Lincoln Cottage and the Administration building, (2) seeks tenants for historic building to not only generate income for the Home's Trust fund but also to offset maintenance and rehabilitation costs of these historic buildings as we have accomplished in Stanley Hall and many of the historic residential buildings on the Home grounds; and (3) has sought, so far unsuccessfully, and will continue to seek and research alternate funding through historical foundations and grants as recommended by the inspection team.

29. FINDING H-02: AFRH-Washington did not maintain an Energy Conservation Program.

Comment: Although AFRH-Washington has no formal written program, aggressive measures have been taken over the past few years to reduce our energy consumption. A major chiller replacement project within the Scott Building, replaced four antiquated units with three new high efficiency chillers thus reducing our electrical demand during the summer months. In addition, the complete closure and "mothballing" of unused structures has had a profound impact on both electric and natural gas usage. This reduction in square footage use resulted in an 8.8% KWh reduction and a 9.4% Therms reduction between FY04 and FY05. An Electrical/Mechanical Engineering Technician position is currently being recruited, which includes duties for Energy Conservation projects and general facilities conditions that would impact energy usage. Campus Ops will increase emphasis on both awareness and documenting compliance with Executive Order 13123.

30. FINDING I-01: AFRH did not establish formal policy and guidance for baseline campus security standards.

Comment: AFRH needs to develop an "Agency" baseline standard. Currently the AFRH-Washington campus does have formal policies in place regarding AFRH-Washington campus security standards. Prior to Hurricane Katrina, AFRH-Gulfport also had campus security standards. Since the Gulfport standards need to be revisited, the focus will now be to establish "Agency" security standards.

31. FINDING J-06: AFRH-Washington's Risk Management Incident Reporting process and coordination were lacking.

Comment: Incident Reporting procedures will be revised as part of the re-alignment of the Safety Committee and the revision of the Incident Reporting form. Incident Reporting will be submitted within 24 hours of the occurrence of the incident. Workman's Comp injuries will have a sign off sheet attached to the CA-1 Form (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation) requiring the signature of the Safety Officer

before submittal. On a weekly basis, the Safety Office will check BPD to insure that all incident reports have been properly recorded at both locations. These changes will be presented to the March 23, 2006 convening of the Safety Committee.

32. FINDING J-07: AFRH-Washington fishing pond and surrounding structures were not properly maintained

Comment: The AF IG team visited shortly after a severe storm brought down several extremely large trees causing substantial damage to the fencing surrounding the fishing pond area. As a part of the clean-up process, AFRH is repairing/replacing the damaged portions of the fence. Repair to the pond wall had already been identified as a potential long range project since it did not pose an immediate safety hazard of failure.

33. FINDING J-08: AFRH-Washington golf course did not have a constructed walkway or approved storage location.

Comment: The area above the locker room ceiling is no longer used as a storage area. Work Request 06-001916 has been submitted by Resident Services to construct a walkway. This minor construction project will be included in the Capital Projects Plan.

34. FINDING L-01: AFRH-Washington's Chief of Resident Services did not file deceased resident's will with the proper court.

Comment: In light of the recent opinion of the District of Columbia Court of appeals interpretation 0f 20 USC ss 420(a)(1) that requires wills or instruments of a testamentary nature involving property rights in AFRH's possession at the time of death be turned over to the court of record, the policy of AFRH is: Wills or instruments of a testamentary nature involving property rights will not be kept in the possession of the AFRH or its employees. Residents of the AFRH may provide information as to the location of a will which will be maintained in the Resident Record; however, no originals/copies will be accepted for safekeeping by the AFRH.

Any original will or instrument involving property rights already in the possession of the AFRH have been relinquished to the owner of that instrument. If a will or instrument of a testamentary nature involving property rights should be discovered in the possession of the AFRH at the time of a resident's death, it will be immediately turned over t the District of Columbia Probate court by an employee designated by the Chief of Resident Services.

35. FINDING M-01: Agency level standardization policy and guidance for AFRH Recreation, Leisure and Wellness (RWL) program were lacking.

Comment: See response to Finding A-02.

AIR FORCE TRIENNIAL REVIEW

AFRH-GULFPORT FINDINGS NOT ADDRESSED DUE TO HURRICANE KATRINA

Finding Number	Finding	Status/Rationale
J-01	AFRH-G facilities had limited disability access	Not addressed due to Hurricane Katrina
J-02	AFRH-G mandated OSHA training was not properly Managed	Not addressed due to Hurricane Katrina
J-03	AFRH-G pool facility had structural deficiencies	Not addressed due to Hurricane Katrina
J-04	AFRH-G skills craft shop was not in compliance with Woodworking Cod of Federal Regulations (CFR) requirements.	Not addressed due to Hurricane Katrina
J-05	AFRH-G auto hobby shop did not meet U.S. Environ- Mental Protection Agency (EPA) Clean Water Act of 1977 requirements	Not addressed due to Hurricane Katrina

Attachment B to AFRH Response